

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07606

7626

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waugh Ave.		d. STREET ADDRESS Waugh Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Louise	Last Allen	4. DATE OF DEATH July 7, 1958	Month July	Day 7	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS Days 4	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Whitcomb		14. MOTHER'S MAIDEN NAME Amanda Baublitz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Florence Wesley, Glyndon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Due to (c) DUE TO Hyper tension -		<i>Coronary Thrombosis</i> <i>arteriosclerosis-general</i> <i>Hyper tension -</i>				10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy.	Year	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Reisterstown</i>	(County) (State) <i>Md.</i>
21. I certify that I attended the deceased from 7-1- 19 58 , to 7-7-1958 , that I last saw the deceased alive on 7-1-1958 , and that death occurred at 7-7-1958 , M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Reisterstown, Md.</i>	
ACTUAL SIGNATURE <i>James G. Paffell</i>		DATE SIGNED <i>7-7-1958</i>					
PHYSICIAN'S NAME (Type) <i>James G. Paffell</i>		M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Reisterstown Methodist		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 9 '58		24b. REGISTRAR'S SIGNATURE <i>Alt. research</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	50	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
101 W. 10TH ST.	APT. 2B	BROOKLYN	N.Y.
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME	
DR. JAMES J. O'LEARY	HOSPITAL	WILLIAMS & SONS	
PHONE NUMBER	NAME OF MORTICIAN	PHONE NUMBER	
212-533-1234	JOHN WILLIAMS	212-533-1234	
DATE OF DEATH	TIME OF DEATH	DATE OF CERTIFICATE	
NOVEMBER 20, 1985	10:30 P.M.	NOVEMBER 21, 1985	
NAME OF SIGNER	RELATIONSHIP	SIGNATURE	
JOHN WILLIAMS	MORTICIAN	JOHN WILLIAMS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07607

7627 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b RURAL and give nearest town Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Cherrydell Rd.		e. STREET ADDRESS 106 Cherrydell Rd.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles T. Anderson		4. DATE OF DEATH July 5, 1958	Month Day Year July 5, 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1891
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME C.H. Anderson		14. MOTHER'S MAIDEN NAME Clara Dowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. C.T. Anderson 106 Cherrydell Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Hours 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 5, 1958</u> to <u>July 5, 1958</u> that I last saw the deceased alive on <u>July 5, 1958</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Donald W. Lapp, M.D. 4805 Frederick Ave., 29 7/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-58	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.
22d. LOCATION (City, town, or county) Balto.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR JULY 10 1958 DATE	24b. REGISTRAR'S SIGNATURE Albert Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be retained by the funeral director.

page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07608

Reg. Dist. No.

7628 CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Maryland Ave	d. STREET ADDRESS 106 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nellie Reeve Askew	First	Middle	Last		
4. DATE OF DEATH July 8	Month	Day	Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 12 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY Accountant		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME John L. Reeve		14. MOTHER'S MAIDEN NAME Catherine Cahill		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles R. Askew-106 Maryland Ave-Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brucellosis, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Diffuse metastases to vertebrae & ribs</u> 3 months DUE TO (c) <u>a carcinoma, left breast</u> 1 year					
INTERVAL BETWEEN ONSET AND DEATH 72 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>411X</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1958</u> to <u>July 8, 1958</u> , that I last saw the deceased alive on <u>July 8, 1958</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Patrick C. Phelan, M.D.		ADDRESS (Street, city or town, state) <u>201 W Madison St - Baltimore, Md.</u> DATE SIGNED <u>7/11/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius Cemetery	
22d. LOCATION (City, town, or county) Hickory, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc 1050 York Rd. Towson		ADDRESS		24a. REC'D BY REGISTRAR DATE JULY 14 '58	
				24b. REGISTRAR'S SIGNATURE <u>John Cook</u>	

DP-P.C.THEKAN-3561YORK RD - 9 PM

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Maryland</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i> Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	c. LENGTH OF STAY IN 1b <i>11/2</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burtonsville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2900 Hillcrest Road</i>	e. STREET ADDRESS <i>150-2</i>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>SARA EVA Athey</i>	First <i>Eva</i>	Middle <i></i>	Last <i>Athey</i>	4. DATE OF DEATH <i>July 6 1958</i>	Month <i>July</i>	Day <i>6</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27 1887</i>	9. AGE (in years last birthday) <i>70</i>	10. IF UNDER 1YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Name</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>William Rich</i>	14. MOTHER'S MAIDEN NAME <i>Belinda Crasdale</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213-24-2736</i>	17. INFORMANT <i>Mrs. David L. Brown, Burtonsville Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>							
DUE TO <i>(c)</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month, Day, Year <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>	DATE SIGNED <i>7/6/58</i>						
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION/ REMOVAL (Specify) <i>Burial July 9, 1958</i>	22b. DATE THEREOF <i>July 9, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Union Cemetery</i>	22d. LOCATION (City, town, or county) <i>Burtonsville, Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Randolph, Laurel Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>Altough</i>	24b. REGISTRAR'S SIGNATURE <i>Altough</i>				
VS. AISM(E) 5M 9/55		DATE JUL 10 '58					

47-19400-1
WEDNESDAY NOVEMBER 25 1942
1730 ZULU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07610

7630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY		Baltimore MARYLAND		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Owings Mills, Maryland		1 year		X Baltimore 6, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
Rosewood State Training School				8200 Pulaski Highway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Zigmund	Last Basilone	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	Month 7 Day 9 Year 1958
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/15/45	9. AGE (In years lost birthday) 13 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Peter Joseph Basilone		Theresa Ledenyja LADANYI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bacillus-Pneumonia secondary		One day	
470X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		To Naso-pharyngitis, acute		Two days	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		491+ Cerebral hemorrhage at birth w/ sym. Epilepsy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/20/57, 19, to 7/9/58, 19, that I last saw the deceased alive on 7/9/58, 19, and that death occurred at 8:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harry G. Butler, M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 7/10/58	
PHYSICIAN'S NAME (Type)		Rosewood State Training School, Owings Mills,		Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL JULY 12 - 58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ST STEPHENS CEM	
22d. LOCATION (City, town, or county) BROOKSHAW				(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Nippel Blvd 7110 Belair Rd.		24a. REC'D BY REGISTRAR DATE JUL 14 '58	
				24b. REGISTRAR'S SIGNATURE A. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

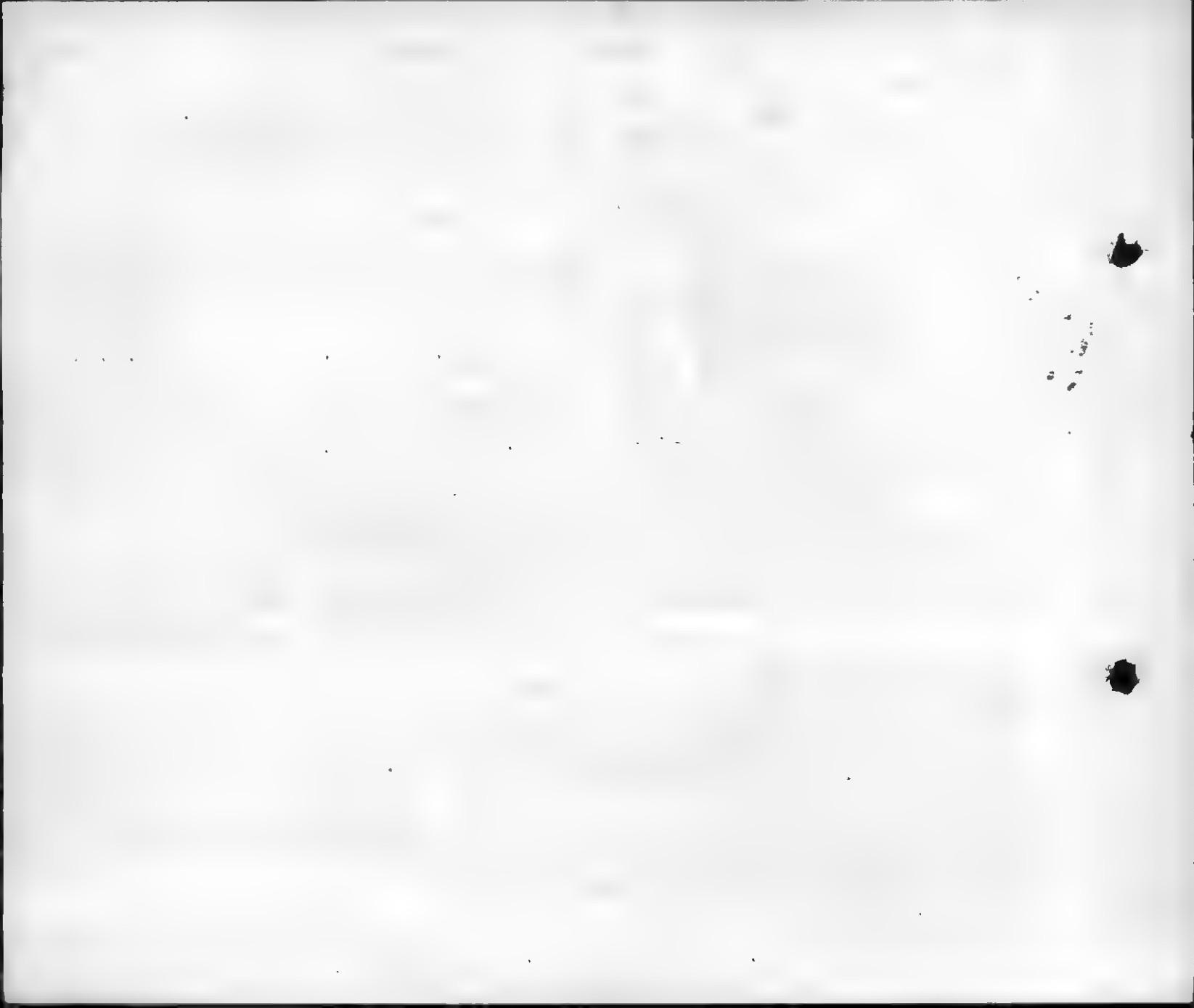
7631 CERTIFICATE OF DEATH

Reg. No. 07611

1. PLACE OF DEATH o COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE MARYLAND	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Carney	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Carney	b. COUNTY Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2640 Matthews Dr.	d. STREET ADDRESS 2640 Matthews	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sydney Winfield Bassford, Sr.	First Sydney	Middle Winfield	Last Bassford, Sr.
4. DATE OF DEATH July 23 1958	Month July	Day 23	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1881
9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Salesman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Bassford	14. MOTHER'S MAIDEN NAME Maggie		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 216-10-6209	17. INFORMANT Mrs. Jeannette Lloyd, 2640 Matthews Dr.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Glucone genitulid eminutus</i> <i>Circumcisio of Pancreas</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1958 to July 1958 , that I last saw the deceased alive on July 23, 1958 , and that death occurred at 4:28 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P. Elliott Young</i>		ADDRESS (Street, city or town, state) 9100 Harford Rd., Baltimore 14 Md. 21208	
PHYSICIAN'S NAME (Type)		DATE SIGNED 7-24-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/26/58	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore	22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. 5305 Harford Rd.		24a. REC'D BY REGISTRAR Jul 25 '58	24b. REGISTRAR'S SIGNATURE Qwest Search

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use in burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07612

7632 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 39 DAYS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle R	Last BAUGHMAN			
4. DATE OF DEATH	Month JULY		Day 12	Year 1958		
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 15, 1890	9. AGE (in years lost birthday) yrs. 67	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDANT TRUCKS		10b. KIND OF BUSINESS OR INDUSTRY OIL COMPANY		11. BIRTHPLACE (State or foreign country) FT. WASHINGTON MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME CHARLES L BAUGHMAN			14. MOTHER'S MAIDEN NAME ELLA McCLELLAN BAUGHMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 238-03-6711		17. INFORMANT Address CLIN REC VET ADM HOSP FT HOWARD MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINO A OF BLADDER 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH 6 Years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)		
21. I certify that I attended the deceased from JUNE 3, 1958 , to JULY 12, 1958 , and that death occurred at 7:20 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7-12-58.						
ACTUAL SIGNATURE <i>Dr. G. C. McElPatrick, M.D.</i>						
DATE SIGNED 7-12-58.						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-15-58		22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Cook-Bright Inc.</i>		ADDRESS 6009 Harford Rd		24a. REC'D BY REGISTRAR 155		24b. REGISTRAR'S SIGNATURE John Cook-Bright Inc.
VS A15 (4) ISM 10/57						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 422 Murdock Rd		STREET ADDRESS 1424 Murdock Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRIET C. (ETTA) BECK		First	Middle
4. DATE OF DEATH July 30 1958		Last	Month
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 17-1888
9. AGE (In years at time of death 70 yrs)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Balt. Md		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Ogle		14. MOTHER'S MAIDEN NAME Delilah C. Shuler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Miss Alice T. Ogle 422 Murdock Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma		19. INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30, 1958, to July 30, 1958, that I last saw the deceased alive on July 30, 1958, and that death occurred at 6 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED 8-1-58-	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 2/58		22b. DATE THEREOF Balt. Cem.	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) Balt. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rock		24a. REC'D BY REGISTRAR ADDRESS 5305 Harford Rd	
		24b. REGISTRAR'S SIGNATURE Aug 4 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on a burial-travel permit. Then please remove carbon papers. Register prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7613 CERTIFICATE OF DEATH

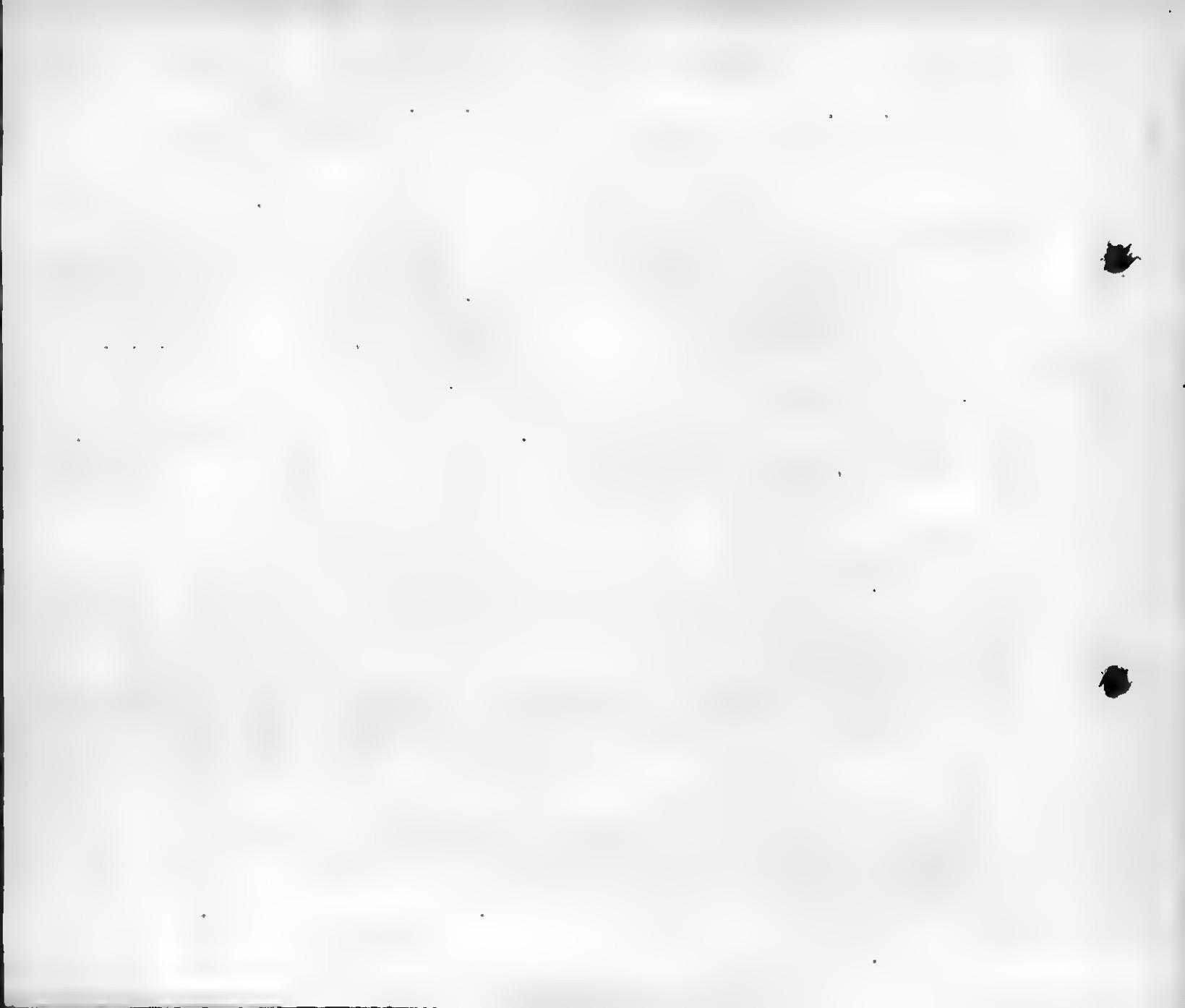
Reg. Dist. No.

07614

1. PLACE OF DEATH a. COUNTY Balto. Md.		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Balto. Md.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 7005 Brentwood Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Irene	Middle May	Last Becker	4. DATE OF DEATH July 27 1958	Month July	Day 27	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1891	9. AGE (In years lost birthday) yrs. 66	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Friedel		14. MOTHER'S MAIDEN NAME Georgeann Oliver						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-5163		17. INFORMANT E. Marie Davis		Address 7005 Brentwood Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CH of transverse Colon		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 78 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		(c) Anemia 12 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2 Kinskip		20f. (City or town) Baltimore		(County) 22 (State) M.D.
21. I certify that I attended the deceased from 7-1 1957 to 7-27 1958 , that I last saw the deceased alive on 7-27 1958 , and that death occurred at 4:30 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 2 Kinskip		DATE SIGNED 7-30-58
ACTUAL SIGNATURE P. A. Collier								
PHYSICIAN'S NAME (Type) Physician's Name								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31 1958		22c. NAME OF CEMETERY OR CREMATORIUM Oaklawn Cem.		22d. LOCATION (City, town, or county) Eastern Ave.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS 3333 Brehms Lane-13		24a. REC'D BY REGISTRAR AUG 1 '58		24b. REGISTRAR'S SIGNATURE Albert Schimunek		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07615

7634 CERTIFICATE OF DEATH

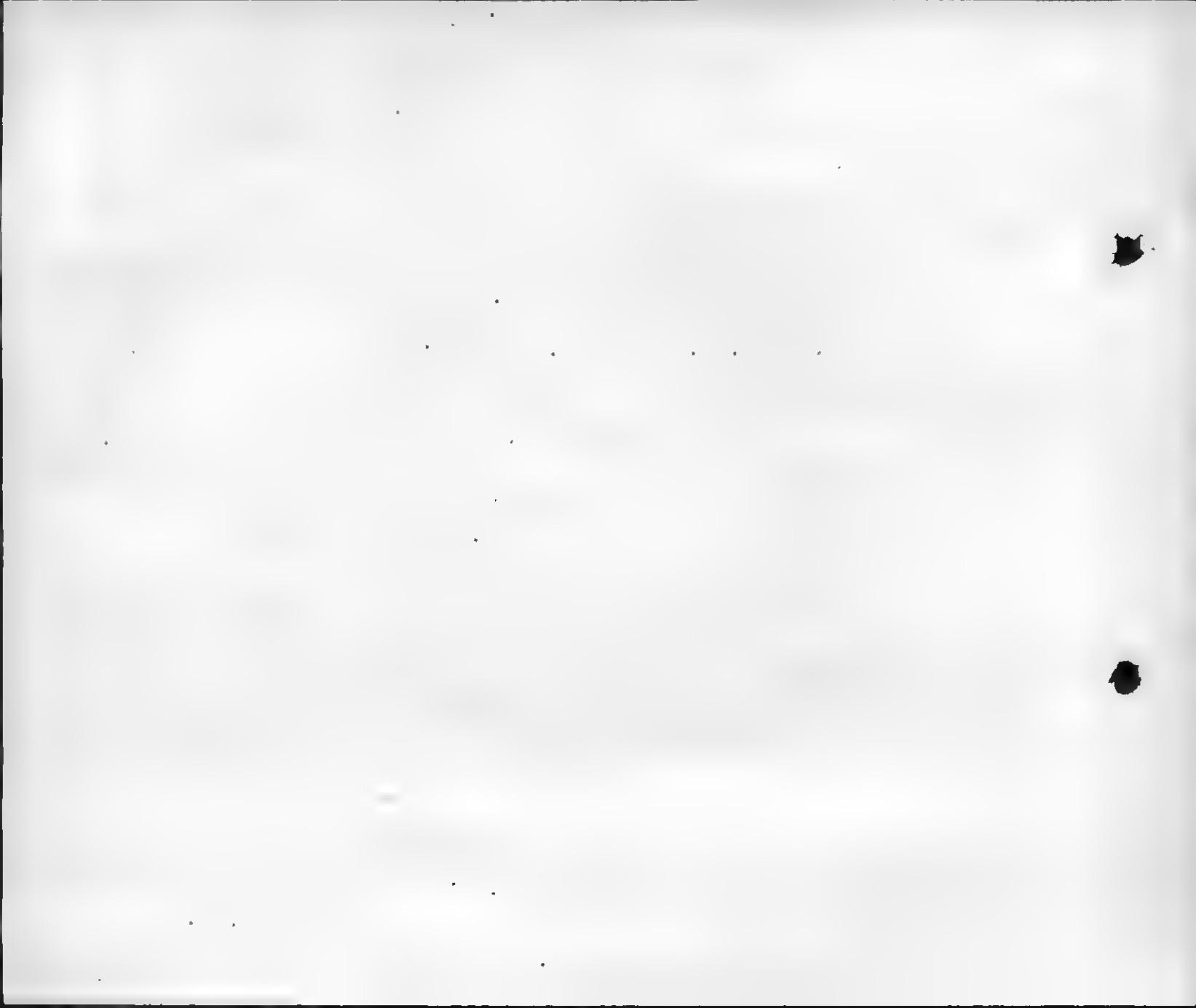
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Delight Road		e. STREET ADDRESS 102 Delight Road	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Howard Bell		First James	Middle Howard
Last Bell		4. DATE OF DEATH July 18, 1958	Month Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1890
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Capt. Balto. Co. Fire Dept.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Walter W. Bell		14. MOTHER'S MAIDEN NAME Isabelle Figg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-22-0263	
17. INFORMANT Mrs. Elsie M. Bell, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO +20.1		10 MIN.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterosclerotic Cardio-Vascular Disease DUE TO		3 4 yrs.	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1, 1958 , to July 18, 1958 , that I last saw the deceased alive on July 15, 1958 , and that death occurred at 11:00 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) 48 MAIN ST., REISTERSTO., MD.	
ACTUAL SIGNATURE Martin E. Strobel		DATE SIGNED 7/18/58	
PHYSICIAN'S NAME (Type) MARTIN E. STROBEL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22/58	
22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D. BY REGISTRAR JUL 23 1958	
		24b. REC'D. BY CLERK John J. Eline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-travel permit. Then please remove carbon papers. Page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7635 Tens 2,4 D15 232 H/15/11-79
CERTIFICATE OF DEATH

07616

Reg. Dist. No.

PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>COTONSVILLE</i>	c. LENGTH OF STAY IN 1b <i>5 DAYS</i>	b. COUNTY <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: <i>THE WAYNE NURSING HOME</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. STREET ADDRESS <i>2207 Lanvale St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ELsie</i>	First <i>Vera</i>	Middle <i>BIRMINGHAM</i>	4. DATE OF DEATH <i>JULY 2, 1958</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-30-87?</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESTAURANT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>LAPKIN H. BIRMINGHAM ELEN BURNIE</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John D. Wayson</i>		14. MOTHER'S MAIDEN NAME <i>FRANCIS E. Wayson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>216-09-1473A</i>	
17. INFORMANT <i>STEWART JONES</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hemiplegic Left.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Congestive Heart failure</i> (b) DUE TO (c) Pneumonia.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6/28/58</i>		20f. (City or town) <i>7/2/58</i>	
(County) <i>7/2/58</i>		(State) <i>7/2/58</i>	
21. I certify that I attended the deceased from alive on <i>6/30/58</i> , and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd</i>	
ACTUAL SIGNATURE <i>W. E. McGloth</i>		DATE SIGNED <i>7/2/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>7-4-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>LONDON PARK CEMETERY</i>		22d. LOCATION (City, town, or county) <i>FREDERICK RD/BALTIMORE, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Tolson 2359 Washington Blvd.</i>		ADDRESS <i>Edward Tolson 2359 Washington Blvd.</i>	
24a. REC'D BY REGISTRAR <i>JUL 7 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Quinn</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7636 CERTIFICATE OF DEATH

07617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Stoneleigh		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home		d. STREET ADDRESS 307 Dixie Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Sara		First Sara	Middle Blake	Last Watson	4. DATE OF DEATH Month July Day 31 Year 1958					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1885	9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New Orleans		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Watson		14. MOTHER'S MAIDEN NAME Rosalea Lombard								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Linwood Belt Cedar Lane Kingsville				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17 4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Terrestrial Failure		INTERVAL BETWEEN ONSET AND DEATH 3 days						
		Carcinomatosis		14 months						
		Carcinoma of Uterine Organs		14 "						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Maryland	(State) MD	
21. I certify that I attended the deceased from 6/19 , 19 57 , to 7/31 , 19 58 , that I last saw the deceased alive on 7/31 , 19 58 , and that death occurred at 5:40 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 200 W. Reister Ave Towson MD						DATE SIGNED 8/1/58		
ACTUAL SIGNATURE Tos. A. Stedack										
PHYSICIAN'S NAME (Type) Tos. A. Stedack										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-1958		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Lester J. Funeral Home 2401 Belair Road		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 4 '58		24b. REGISTRAR'S SIGNATURE Alt. esuch				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07618

7637 CERTIFICATE OF DEATH

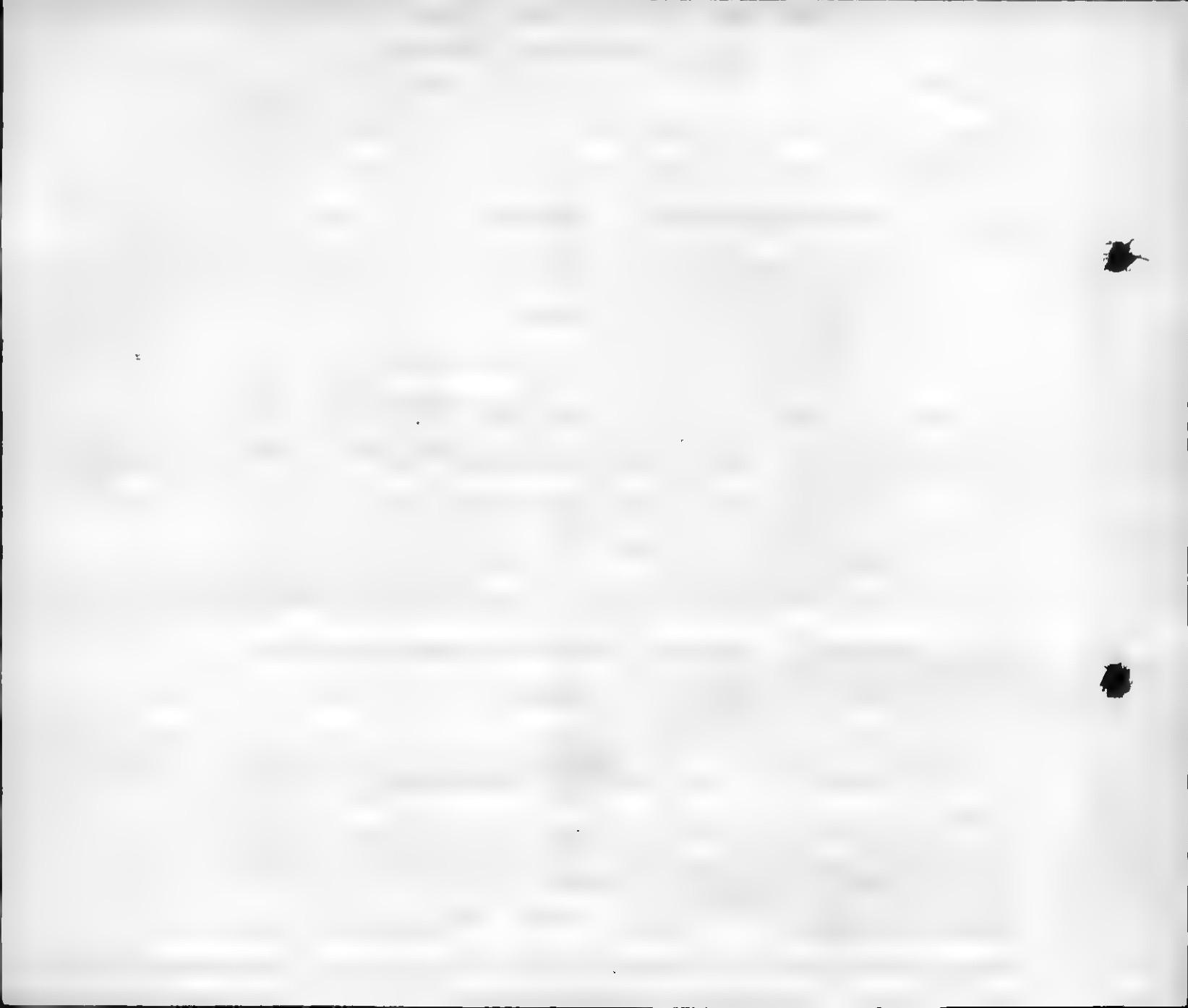
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on a burial-trust permit. Then please remove carbon paper. / Page 3 should be filed with the registrar prior to burial, removal, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gutherville, md.		c. LENGTH OF STAY IN lb 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor.		d. STREET ADDRESS 209 W. Monument St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary Bawbston Bolton		First	Middle	Last	4. DATE OF DEATH July 15 1958	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec 8 1870	9. AGE (in years lost birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS Days 7	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer for out of town people Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, md.		11. BIRTHPLACE (State or foreign country) Baltimore, md.				
13. FATHER'S NAME William Bawbston Bolton		14. MOTHER'S MAIDEN NAME Mary Murray Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Eleanor Pope 211 W. Monument St.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		DUE TO Bronch pneumonia				INTERVAL BETWEEN ONSET AND DEATH days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. General arteritis senectus.		(b) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General arteritis senectus.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 1101 11. Calwest St., Baltimore	20f. (City or town) Baltimore	(County) Md	(State) Md
21. I certify that I attended the deceased from July 28 1958 , 19 58 , to July 15 1958 , 19 58 , that I last saw the deceased alive on July 14 1958 , and that death occurred at 11:27 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1101 11. Calwest St., Baltimore DATE SIGNED 7/14/58								
ACTUAL SIGNATURE Ernest C Brown Jr.		PHYSICIAN'S NAME (Type) Ernest C Brown Jr.						
22a. BUR AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Green Mount Cemetery		22d. LOCATION (City, town, or county) Baltimore Md		
23. FUNERAL DIRECTOR'S SIGNATURE Henry W Jenkins & Sons Co. 4905 York Road		ADDRESS 1101 11. Calwest St., Baltimore		24a. REC'D BY REGISTRAR JUL 17 '58		24b. REGISTRAR'S SIGNATURE Reba Lewis		



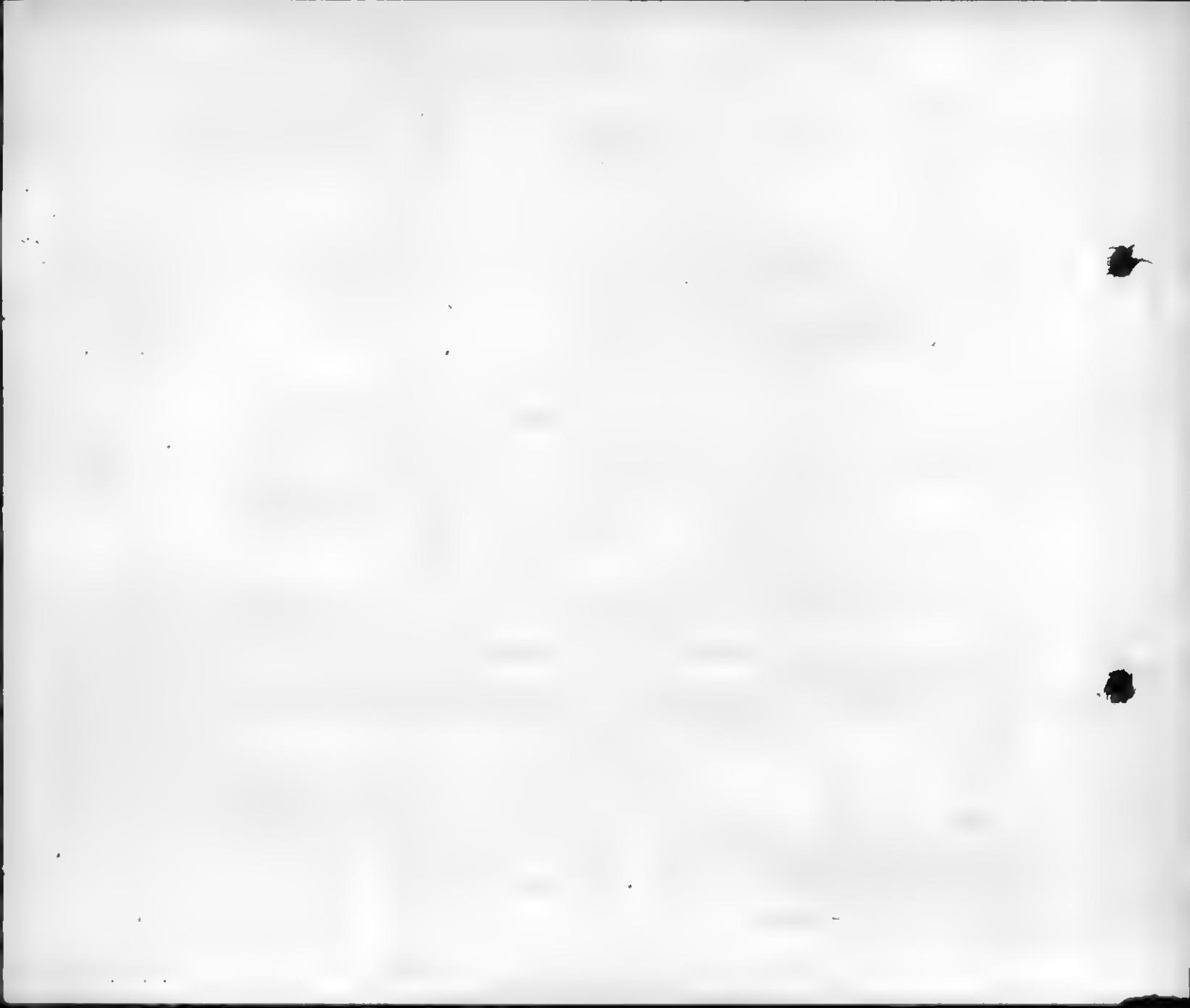
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7638 CERTIFICATE OF DEATH

07619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. LENGTH OF STAY IN lb 8 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8045 Liberty Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale	
3. NAME OF DECEASED (Type or print) Hamilton Francis Brunner		First Hamilton	Middle Francis
4. DATE OF DEATH July 4, 1958.		Last Brunner	Month July
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1905
9. AGE (In years less birthday) 52 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Good Humor	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Claud Brunner		14. MOTHER'S MAIDEN NAME Catherine Poulsen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 218-09-995	17. INFORMANT Address Ida C. Brunner 8045 Liberty Rd. (7)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X		Metastatic carcinoma, pancreas	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-5-58 , 19..., to 7-4-58 , 19..., that I last saw the deceased alive on 6-30-58 , 19..., and that death occurred at 1291A , M, from the causes and on the date stated above. ACTUAL SIGNATURE Nathan Racusin		ADDRESS (Street, city or town, state) 206 S. Gilmor St. Baltimore Md. DATE SIGNED 97-5-58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-1958	22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn
22d. LOCATION (City, town, or county) Woodlawn		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong 3907 North Ave,		24a. REC'D BY REGISTRAR DATE JUL 8 1958	24b. REGISTRAR'S SIGNATURE Alv. L. Cook



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07620

7639

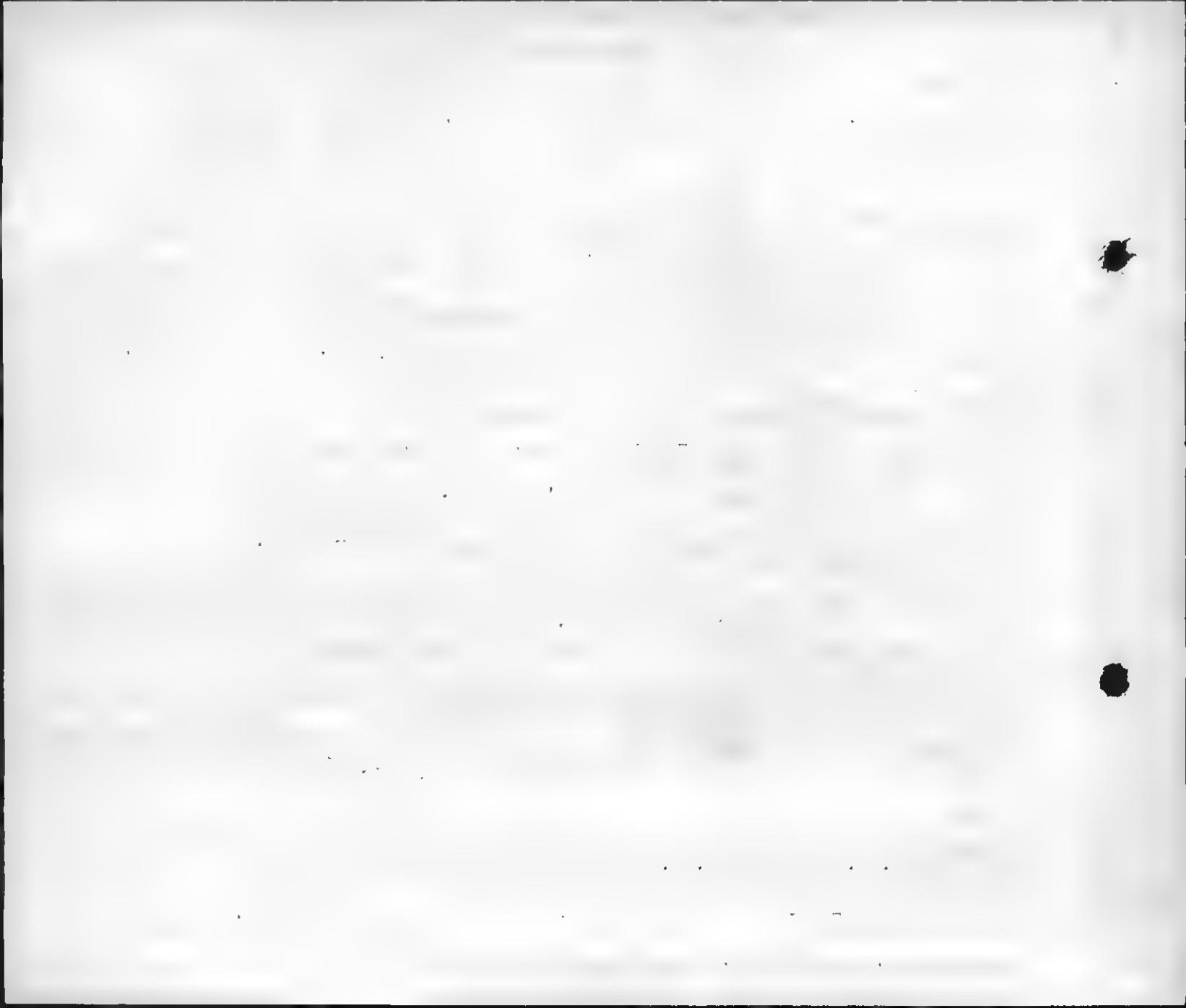
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>		c. LENGTH OF STAY IN 1b <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>El Ray Farms</i>		d. STREET ADDRESS <i>El Ray Farms</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Ray</i>	Last <i>Bryson</i>	4. DATE OF DEATH <i>7 22 1958</i>	Month <i>7</i>	Day <i>22</i>	Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27 1879</i>	9. AGE (In years last birthday) <i>78 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i></i>	Days <i></i>	Hours <i></i>	Min <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horse Breeder</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Covington, Ky.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>				
13. FATHER'S NAME <i>Frank Bryson</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Link</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>136-01-6719</i>		17. INFORMANT <i>Mrs. Ella K. Bryson</i>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia; Ludwig's angina</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Multiple myeloma with complete paraplegia.</i> DUE TO (c) <i>Hypertensive cardiovascular disease with old coronary infarct.</i>										
INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>coronary infarct.</i>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from October 1949, to July 22, 1958, that I last saw the deceased alive on July 22nd, 1958, and that death occurred at 11:30 AM. From the causes and on the date stated above.									ADDRESS (Street, city or town, state) <i>Baltimore, Maryland</i>	DATE SIGNED <i>July 23, 1958</i>
ACTUAL SIGNATURE <i>Dr. Rutledge</i>		M.D.		18 East Eager Street						
PHYSICIAN'S NAME (Type) <i>P. H. Rutledge, M. D.</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7-25-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Druide Ridge</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State) <i></i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Hargrave Rd.</i>		24a. REC'D BY REGISTRAR <i>JUL 24 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Q</i>				

X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

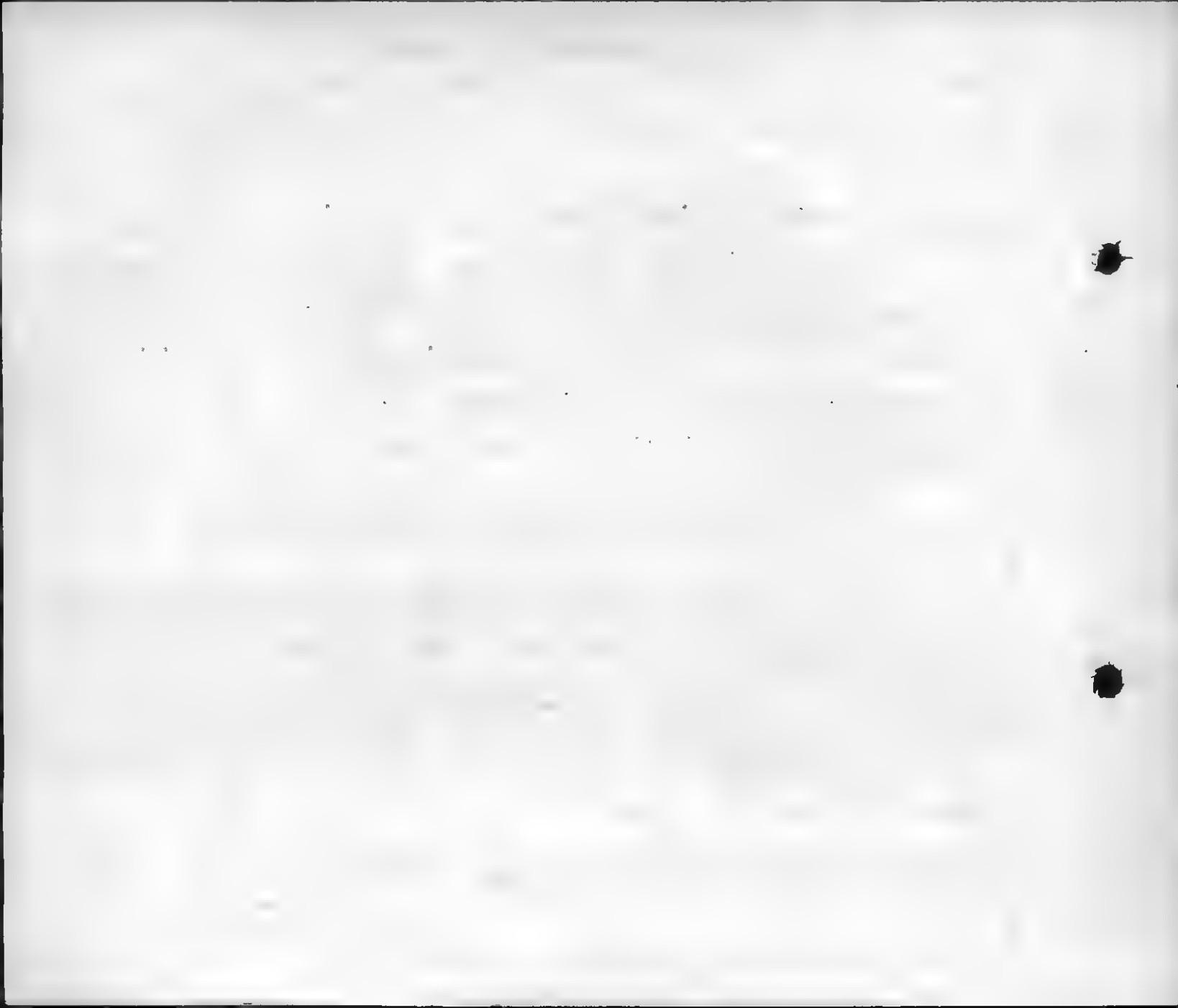
07621

7640 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESEX		c. LENGTH OF STAY IN 1b 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (21)		d. STREET ADDRESS 345 Nickelson Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 345 Nickelson Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Levi Bubb		First	Middle	Last	4. DATE OF DEATH July 20,	Month	Day	Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1886		9. AGE (In years lost birthday) 71	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Luther Bubb		14. MOTHER'S MAIDEN NAME Adeline ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-0 7-8610		17. INFORMANT Margaret Robertson	Address Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		METASTATIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 7 mo.					
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		CARCINOMA OF PROSTATE		1 YR					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 108 S. TAYLOR AVE		(County) BALTO. CO., MD.	(State) MD.
21. I certify that I attended the deceased from JAN 15 1958 to JULY 20 1958 , that I last saw the deceased alive on JULY 18 , 19 58 , and that death occurred at 10 P.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE					DATE SIGNED 7/21/58
ACTUAL SIGNATURE <i>Joseph Nigroli</i>		M.D.							
PHYSICIAN'S NAME (Type) JOSEPH NIGROLI M.D.		BALTIMOIRE 21, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/58		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		22d. LOCATION (City, town, or county) BALTO. CO., MD.			(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE James E. Brudzinski		ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR DATE JUL 23 '58		24b. REGISTRAR'S SIGNATURE Albert J. Schaefer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with page 3 should be detached for use as a burial-trust permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

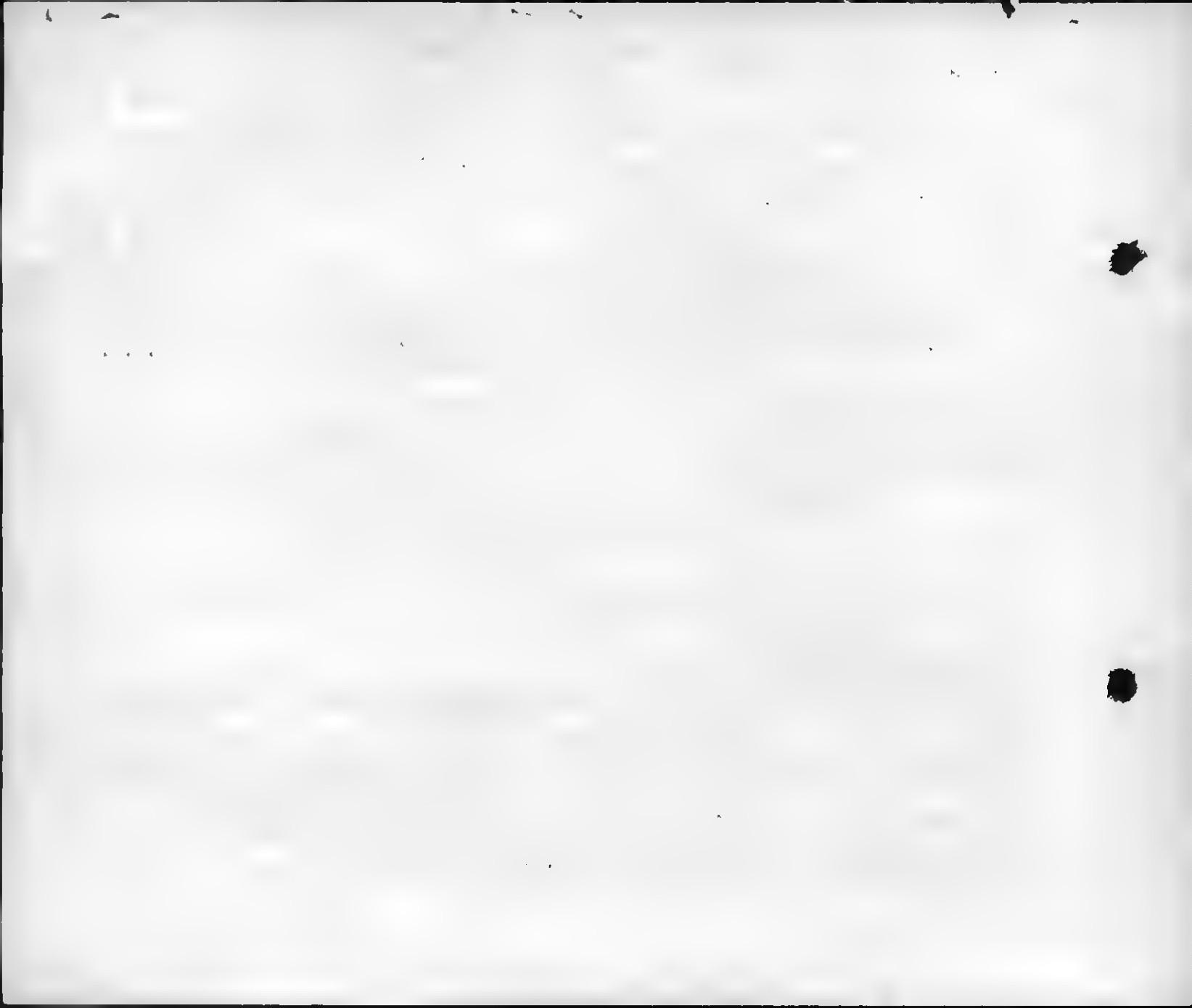
7641 CERTIFICATE OF DEATH

07622

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after both.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 47 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) LAWRENCE		First LAWRENCE	Middle E
		Last BUCHANAN	4. DATE OF DEATH JULY 12 1958
5. SEX MALE		6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 12-25-1889	
9. AGE (In years lost birthday) yrs. 68		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY SHOE SHOP	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE BUCHANAN	
14. MOTHER'S MAIDEN NAME ALICE DETT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) YES WW-1	
16. SOCIAL SECURITY NO. 213-34-3455		17. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) NEPHRITIS		INTERVAL BETWEEN ONSET AND DEATH YEARS 13X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO BRAIN STEM HEMORRHAGE		2-3 DAYS	
(c) HEMOLYTIC ANEMIA		WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 26, 1958, to JULY 12, 1958, and that death occurred at 2:30 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 7-13-58	
ACTUAL SIGNATURE Vincent S. Mikoloski		M.D. VAH FORT HOWARD MARYLAND	
PHYSICIAN'S NAME (Type) VINCENT S MIKOLOSKI		21. D. VAH FORT HOWARD MARYLAND 7-13-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/16/1958	22c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND	(State)
ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 14 '58	24b. REGISTRAR'S SIGNATURE Alv. Cooley



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07623

7642

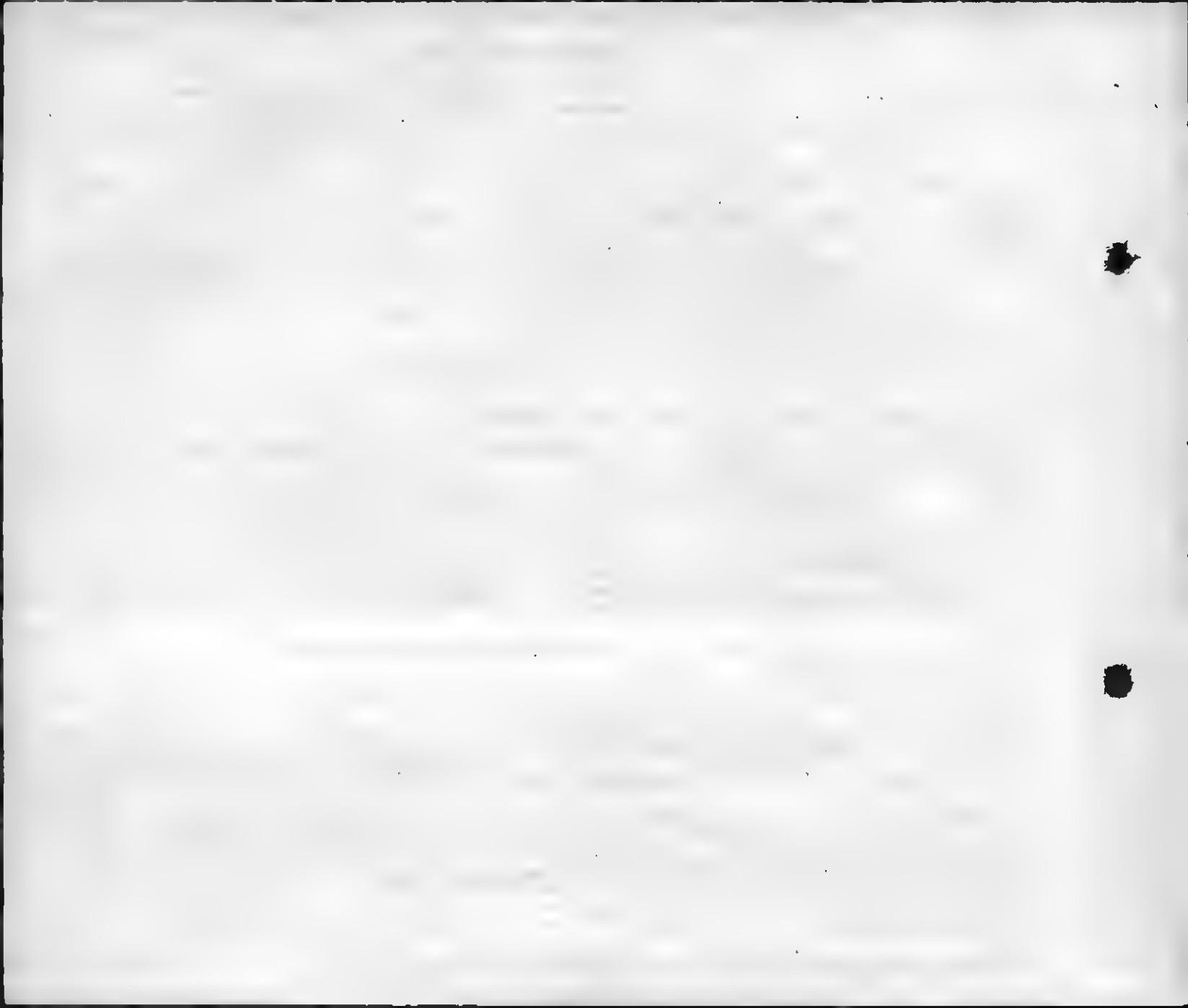
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. STATE Md. b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Joseph	Middle P	Last Campbell	4. DATE OF DEATH Month July Day 20 Year 1958
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 11, 1883	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACINTISH		11. BIRTHPLACE (State or foreign country) SCOTLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		10b. KIND OF BUSINESS OR INDUSTRY STEEL		13. FATHER'S NAME CAMPBELL	
14. MOTHER'S MAIDEN NAME O'DOYLE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO.		16. SOCIAL SECURITY NO. J P CAMPBELL ROUTE 1, FENTRESS VA	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO multiple myeloma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1825 Eastern Blvd ACTUAL SIGNATURE A. L. Kalodny M.D. DATE SIGNED 7/21/58 PHYSICIAN'S NAME (Type) A. L. Kalodny, M.D. BALTIMORE 21, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 7/22/58		22b. DATE THEREOF 7/22/58		22c. NAME OF CEMETERY OR CREMATORIUM OHIO LAWN	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME		ADDRESS PUNDALYN		24a. REC'D BY REGISTRAR DATE JUL 23 '58	
				24b. REGISTRAR'S SIGNATURE A. L. Kalodny	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, block 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trust permit. Then please remove carbon papers. Page 4 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

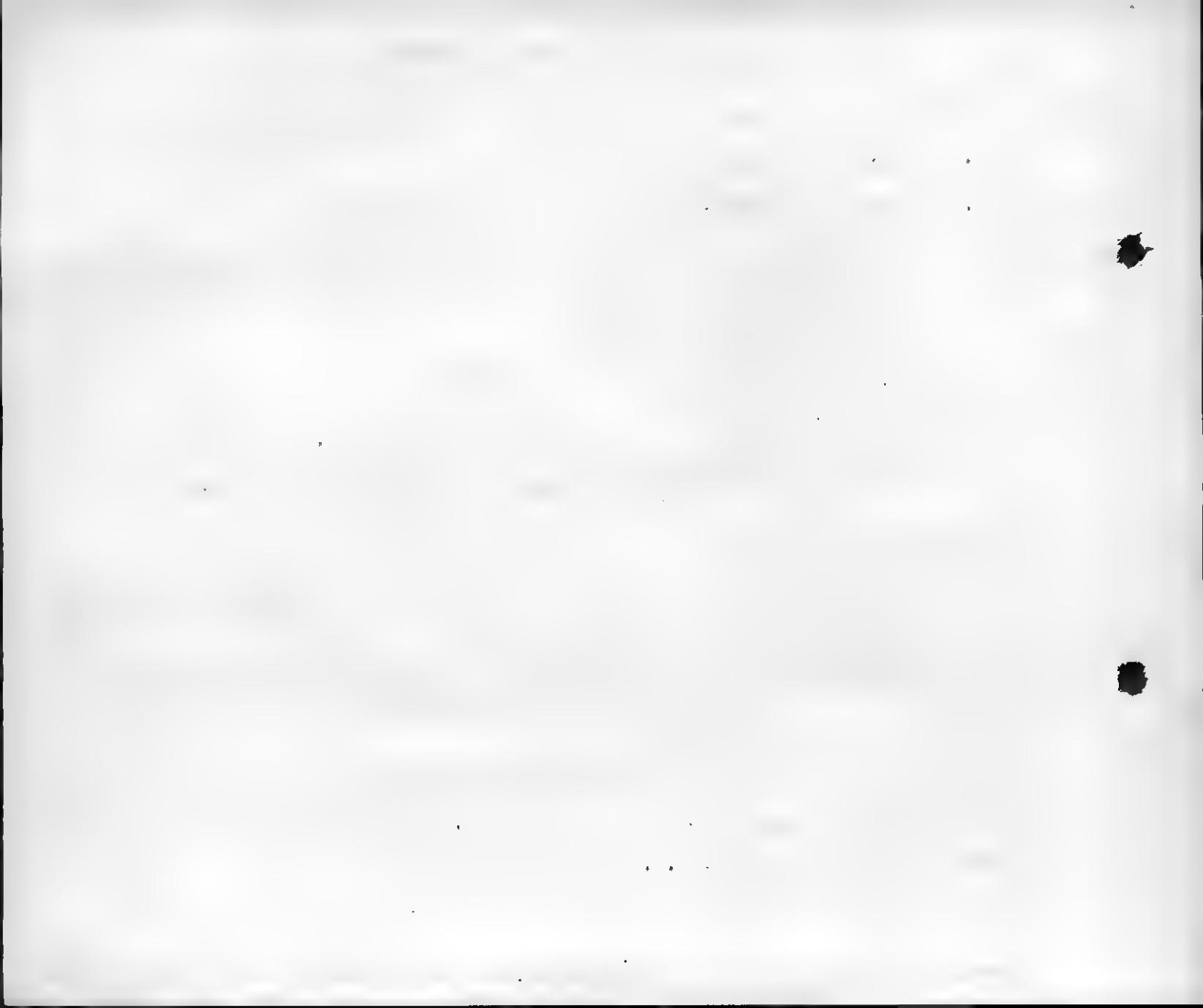
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07624

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Md.		If institution Residence before admission					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 13 mo.		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1702 Noyes Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF George Alexander Carpenter (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/75		9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Francis Asbury		14. MOTHER'S MAIDEN NAME Nannie Lyon									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Moderately advanced pulmonary tuberculosis 2 yrs. INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6/21, 1957 to 7/19, 1958 , that I last saw the deceased alive on 7/19, 1958 , and that death occurred at 4:50 A.M. from the causes and on the date stated above										ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE Whittemore		M.D.		Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type)		William Newcomer, M.D.		Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. 27		22b. DATE THEREOF Jul 21, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Christ Episcopal Chaptico		22d. LOCATION (City, town, or county) Chaptico, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR JUL 22 '58		24b. REGISTRAR'S SIGNATURE Aut. each					
VS A15 (4) 15M 10/57				DATE							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G232 8-19-58 at

7644

CERTIFICATE OF DEATH

07625

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in my event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 5yr 8mths 2dys		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 1 Osborne Avenue		f. DATE OF DEATH July 30	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Bertha		First	Middle	Last	Month Day Year
4. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1880	9. AGE (in years lost birthday) 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Amos Carrick		14. MOTHER'S MAIDEN NAME Susanna Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-8381		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) Arteriosclerotic cardiovascular disease DUE TO (c)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) Baltimore (State) Maryland	
21. I certify that I attended the deceased from July 1, 1953 to July 30, 1958 , that I last saw the deceased alive on July 30, 1958 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 7-31-58					
22a. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		ADDRESS Catonsville 28, Maryland			
22b. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL		22c. DATE THEREOF 8-2-58		22d. LOCATION (City, town, or county) Baltimore (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cok, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 1 '58	
24b. REGISTRAR'S SIGNATURE John Smith					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7645

CERTIFICATE OF DEATH

Reg. Dist. No. 32

17626

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE CITY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 4963 EDGEMERE AVE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BERTHA MAE CARTER		First	Middle	Last	4. DATE OF DEATH JULY 1 1958	Month	Day	Year	
S SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH NOV. 16 1911	9 AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME THOMAS BROWNLEE		14. MOTHER'S MAIDEN NAME SARAH Zowak							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/27 1958 to 7/1 1958 , that I last saw the deceased alive on 7/1 1958 , and that death occurred at 1 P.M. from the causes and on the date stated above ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland		ADDRESS (Street, city or town, state) DATE SIGNED							
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/1958		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill		22d. LOCATION (City, town, or county) Towson		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.		24a. REC'D BY REGISTRAR JUL 2 '58		24b. REGISTRAR'S SIGNATURE Wm. Cook, Inc.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07627

Reg. Dist. No.

7646

Items 8, 10, 11, 12, 13, 14, 21, 22, 232 — 6/1/58 — mb

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

nr. Baltimore

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]

1115 Shefford Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

JOSEPH

CASEY

4. DATE
OF
DEATH

July

Month Day Year

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

Dec. 8, 1906

9. AGE (In years
last birthday)
51 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Clark

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Paltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Sydney Joseph

14. MOTHER'S MAIDEN NAME

Vollie ?

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOC AL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Bronchopneumonia

191X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), slating the underlying
cause lost.
(b) _____
(c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Sydney S. Katz, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7/25/58

22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

Burial July 26-1958 Sacred Heart Cem.

Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE

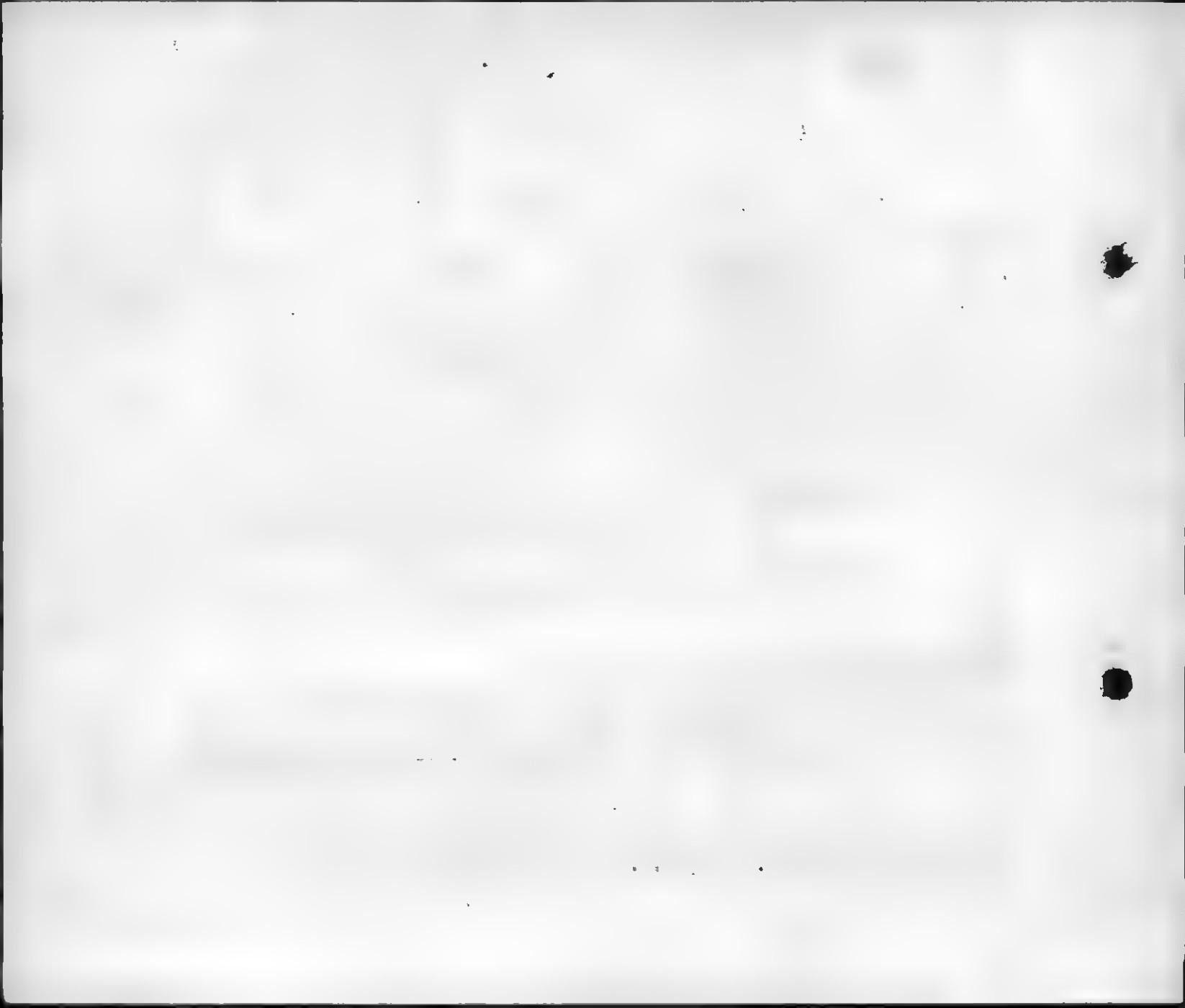
ADDRESS

24a. REC'D BY REGISTRAR

DATE JUL 29 '58

24b. REGISTRAR'S SIGNATURE

DATE Alt. Deuch



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7647

CERTIFICATE OF DEATH

07628

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use on the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore Co.		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		d. STREET ADDRESS 1605 Bellona Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First AGATHE	Middle M	Last CECIL	4. DATE OF DEATH July 10 1958	Month July	Day 10	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 18, 1886	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own-home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Millard Micheal				14. MOTHER'S MAIDEN NAME Porti Gilbert				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma Head of Pancreas				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Hour a. m. p. m.	Month 19	Dey	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Towson	(County) Baltimore	(State) Maryland	
21. I certify that I attended the deceased from Jan 13, 1958 to July 10, 1958 , that I last saw the deceased alive on July 10, 1958 , and that death occurred on July 10, 1958 , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 19 W. Seminary Ave., Lutherville		DATE SIGNED 7/11/58		
ACTUAL SIGNATURE Bennett A. Stoen		M.D.						
PHYSICIAN'S NAME (Type) Bennett A. Stoen		19. W. Seminary Ave., Lutherville		7/11/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cemetery		22d LOCATION (City, town, or county) Towson		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Son's Towson & Ind.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 16 '58		24b. REGISTRAR'S SIGNATURE A. Stoen		



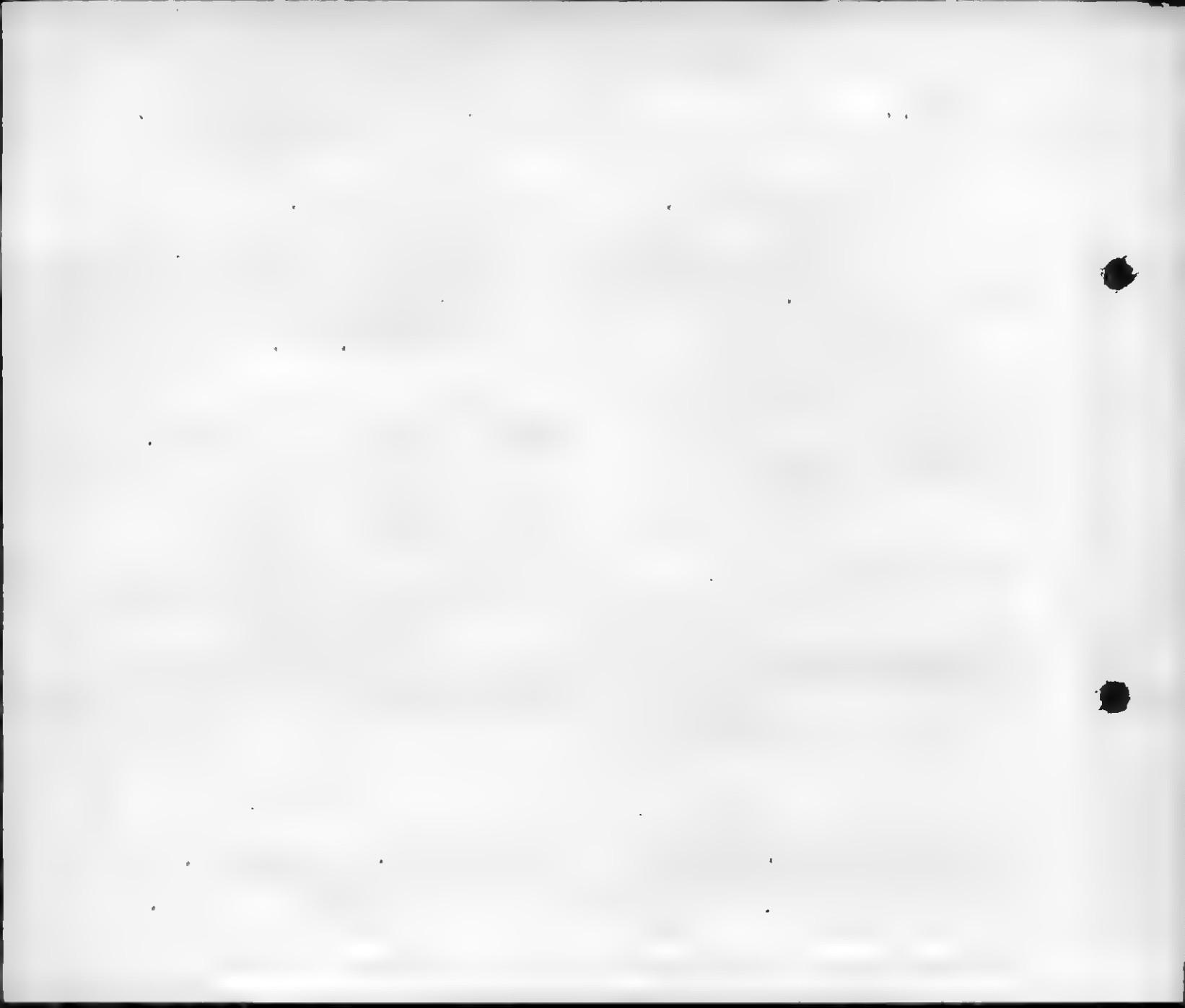
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07629

7623 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md.		b. COUNTY BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethrophe		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethrophe		d. STREET ADDRESS 4300 Ridge Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4300 Ridge Ave.				d. STREET ADDRESS 4300 Ridge Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MARY	Middle AGNES	Last CHISLEY	4. DATE OF DEATH	Month JULY	Day 8,	Year 1958	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1892	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charles Co. Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Samuel Thomas			14. MOTHER'S MAIDEN NAME Julia Green					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT John Chisley		Address 4300 Ridge Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO MYOCARDIAL INFARCTION / VR								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTEROSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTEROSCLEROSIS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June , 1958 to July , 1958, that I last saw the deceased alive on July , 1958, and that death occurred at 11:30 M. from the causes and on the date stated above.								
ACTUAL SIGNATURE George E. Groleau M.D.								
PHYSICIAN'S NAME (Type) George E. Groleau								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Arbutus Memorial Park		22d. LOCATION (City, town, or county) Arbutus		
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Edith R. Williams								
ADDRESS 329 1/2 Main St. Elkridge Md.								
24a. REC'D BY REGISTRAR DATE JUL 14 '58								
24b. REGISTRAR'S SIGNATURE W. L. Smith								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07630

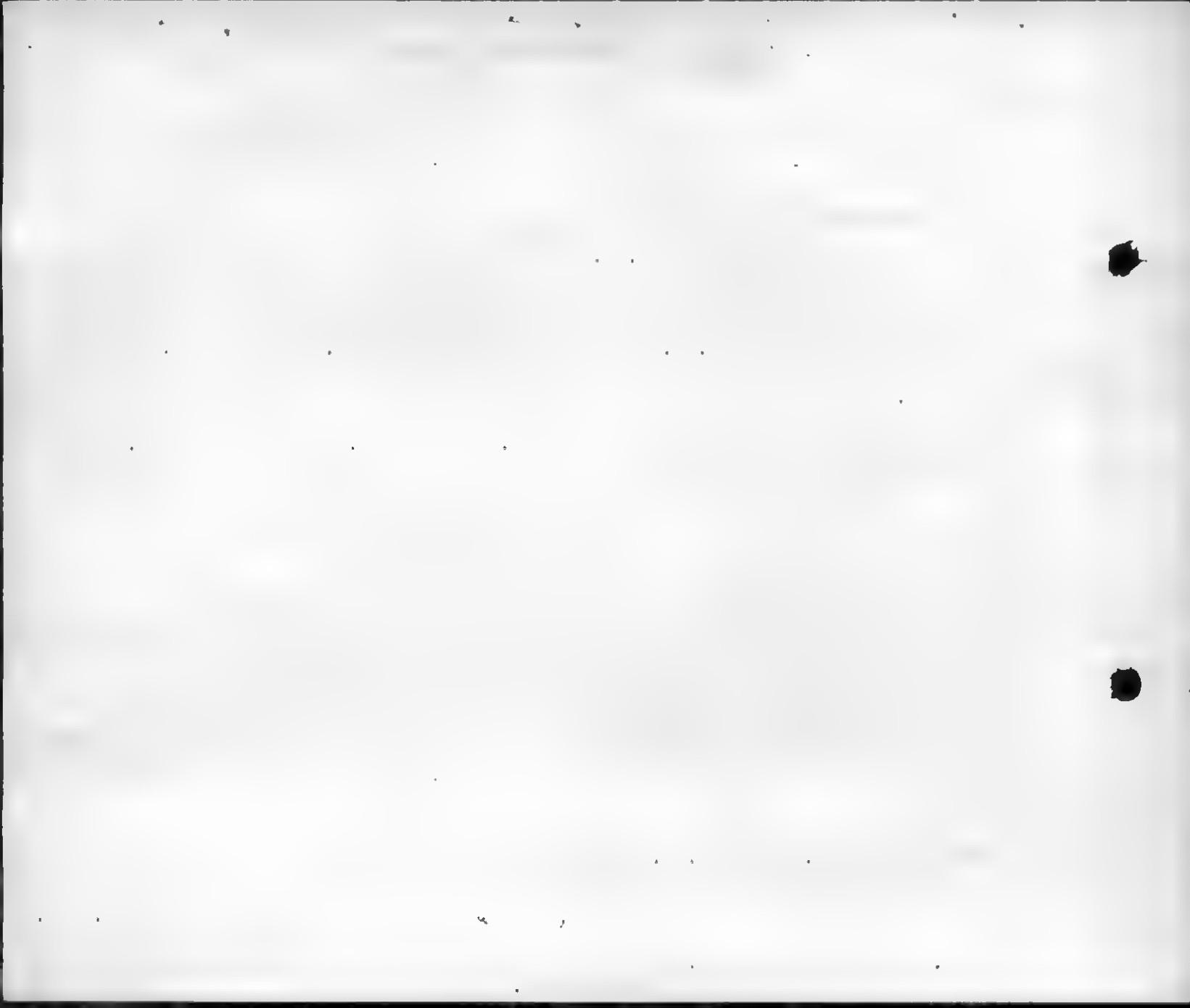
7648 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryalnd		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) F. rt. Howard, Md.		c. LENGTH OF STAY IN 1b 39 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 6 Jade Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Norman	Middle Gregory	Last Clabaugh	4. DATE OF DEATH	Month July	Day 13	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 28, 1894	9. AGE (In years lost/birthday) 64 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poetian		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME John J. Clabaugh			14. MOTHER'S MAIDEN NAME Mary Lashorn						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. none		17. INFORMANT Clin. Records Vet. Adm. Hospital, Ft. Howard, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) FAILOF DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) MYOCARDITIS									
INTERVAL BETWEEN ONSET AND DEATH Minutes									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ft. Howard		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from June 4, 1958, to July 13, 1958, that I saw the deceased alive on 19 and that death occurred at 4:10 PM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 1000 W. 36th Street, Baltimore, Md.									
DATE SIGNED 7/13/58									
ACTUAL SIGNATURE Hiram B. Curry									
PHYSICIAN'S NAME (Type) HIRAM B. CURRY, M. D.		VAH, Fort Howard, Maryland 7/13/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) 2230 Frederick Ave., Balto., Md.			
(State) Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc.		ADDRESS North Avenue, Baltimore, Md.		24a. REC'D BY REGISTRAR JUL 14 '58		24b. REGISTRAR'S SIGNATURE Wm. J. Tickner			
DATE JUL 14 '58									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



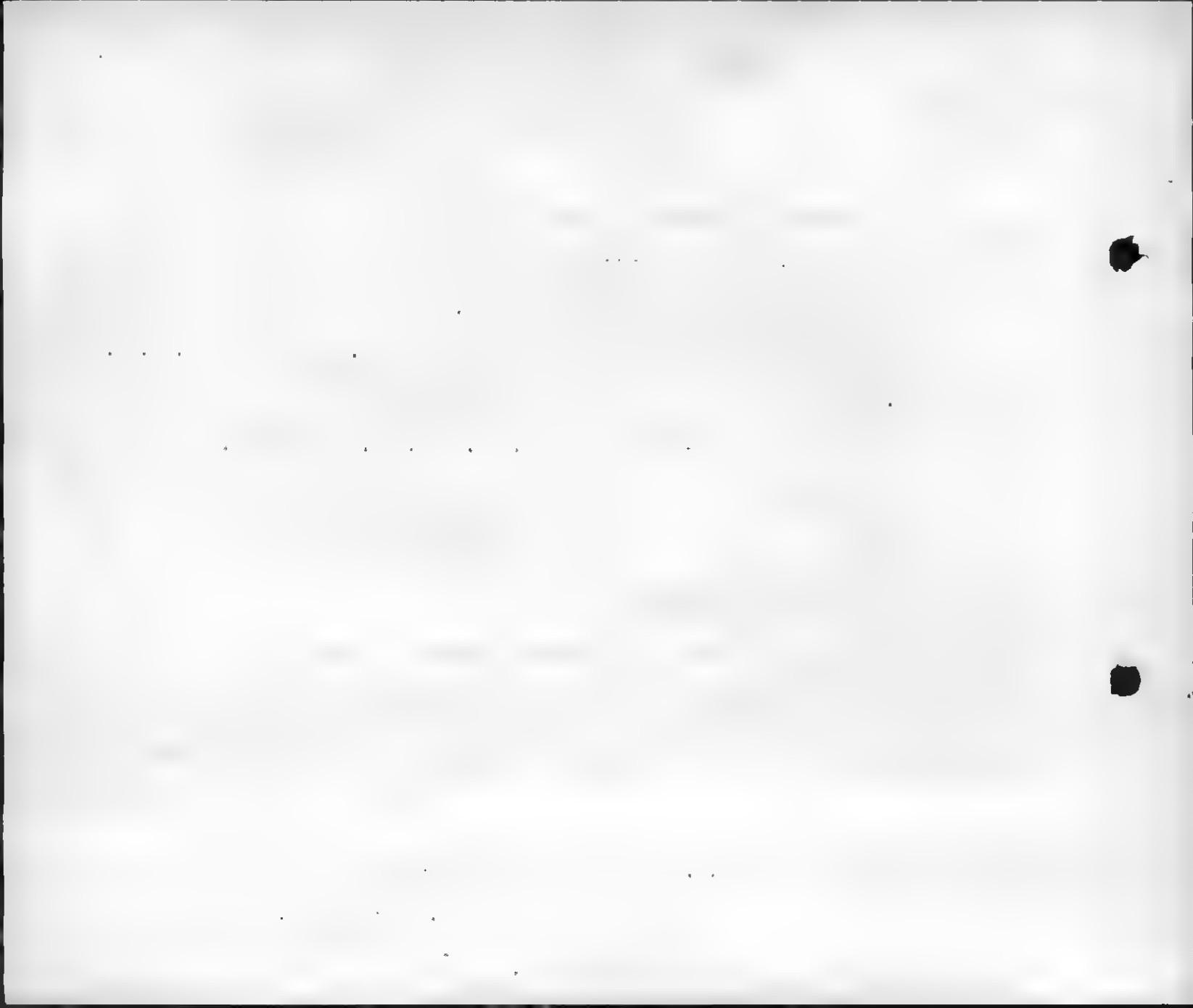
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07631

7649 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Catonsville)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 407 Oella Avenue		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) URIAS	First 	Middle 	Last COLE	4. DATE OF DEATH July 30 1958	Month July	Day 30	Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1892	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME George W. Cole		14. MOTHER'S MAIDEN NAME Mary Henderson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> YES <small>If yes, or unknown (If yes, give war or dates of service)</small> WW I		16. SOCIAL SECURITY NO 218-18-0828		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GENERALIZED PERITONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last 153,8						INTERVAL BETWEEN ONSET AND DEATH 1 + DAY		
{ (b) PERFORATION OF SIGMOID COLON DUE TO (c) CARCINOMA OF SIGMOID COLON						1 + DAY		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						UNKNOWN		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		(County) 		(State)
21. I certify that I attended the deceased from July 28, 1958 , to July 30, 1958 , and that death occurred at 4:25 AM , from the causes and on the date stated above ACTUAL SIGNATURE <i>Chien Wei Lan</i>				ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND		DATE SIGNED 7/30/58		
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH, FORT HOWARD, MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE VS A15 (4) 15M 10/57		ADDRESS 1808-1810 N. Monroe St. Baltimore 17, Md.		24a. REC'D BY REGISTRAR RUG 4		24b. REGISTRAR'S SIGNATURE <i>John J. Keenan</i>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the body for prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 20e Film 222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07632

1. PLACE OF DEATH a. COUNTY Baltimore Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS CHESLEY 3221 Chesley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William James Combs Jr.		First	Middle	Last	4. DATE OF DEATH July 11 1958	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1928	9. AGE (in years last birthday) 30 yrs.	10. IF UNDER 1YEAR Months Days Hours Min		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William James Combs Sr.		14. MOTHER'S MAIDEN NAME Rosa Alise Lewis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-38-8593		17. INFORMANT Mrs. Sarah Jean Combs		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sti 27 regulation 62021</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Brusing injury to neck suddenly</i> DUE TO (c) <i>Cervical Completely Broken Neck + Spine</i> DUE TO								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>161-01 Dump Truck Body Cellophane Wrap</i>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <i>+ causing completely Broken Neck + Spine</i>						
20c. TIME OF INJURY Month, Day, Year Hours a. m. p. m. July 11 1958		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Vacant lot		20f. (City or town) Bethel (County) W. Va. (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Charles F O'Donnell</i>		DATE SIGNED <i>7/12/58</i>						
EXAMINER'S NAME (Type) <i>Charles F O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 12, 58		22c. NAME OF CEMETERY OR CREMATORIAL Welles West Virginia		22d. LOCATION (City, town, or county) Welles West Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Sons</i>		ADDRESS <i>Tolson & 7th</i>		24a. RECD BY REGISTRAR DATE JUL 16 '58		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7651 CERTIFICATE OF DEATH

117633
32

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 183 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital		d. STREET ADDRESS 9 Cornhill Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Agnes Rebecca		First	Middle	Last	4. DATE OF DEATH Month 7	Day 23	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 6/4/07	9. AGE (in years last birthday) 51 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Michael Russell		14. MOTHER'S MAIDEN NAME Marcella Tyson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Dilatation; acute DUE TO 754X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Hypersensitivity to Anaesthesia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mt. Wilson, Maryland		20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from 1/21/1958 to 7/23/1958 , that I last saw the deceased alive on 7/23/1958 , and that death occurred at 5:35 A.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED 7/23/58	
ACTUAL SIGNATURE William Newcomer		M.D.		Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25-58		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		22d. LOCATION (City, town, or county) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Ferguson		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 2 B '58		24b. REGISTRAR'S SIGNATURE John M. Ferguson	



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

7652

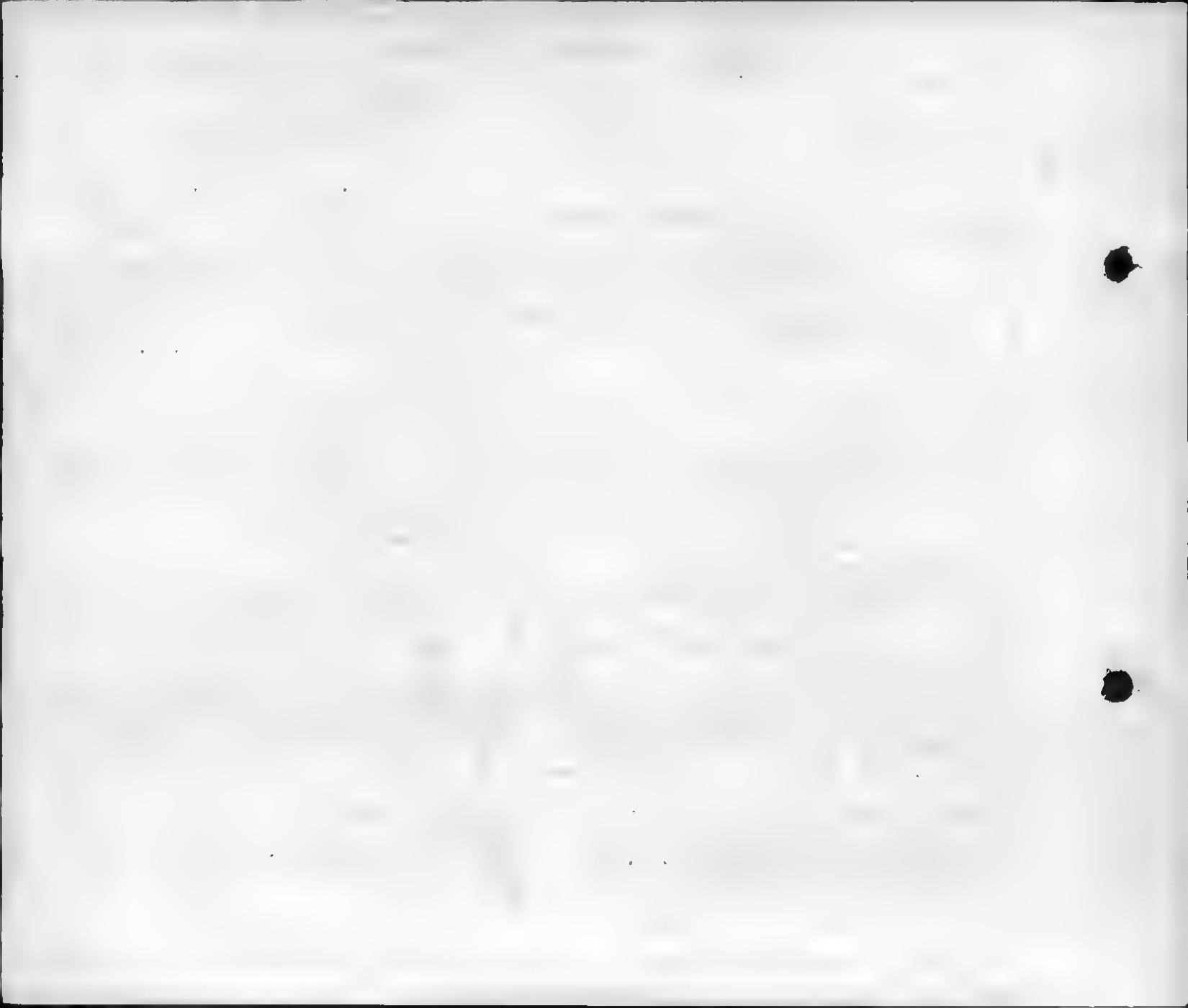
CERTIFICATE OF DEATH

Reg. Dist. No.

07634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 9yr 5mth 17dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 606 N. Kenwood Ave. Rostkobod Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Augusta	Middle	Last Correll	4. DATE OF DEATH July 26	Month July	Day 26	Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1880	9. AGE (In years last birthday) 78?	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Jenn Correll			14. MOTHER'S MAIDEN NAME Annie Sweitzer			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. no		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		
4/22/58						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. { (b) _____ DUE TO Generalized arteriosclerosis (c) _____ DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Spring Grove	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from July 1, 1958 , to July 26, 1958 , that I last saw the deceased alive on July 26, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-28-58								
ACTUAL SIGNATURE <i>Stella Wachsler</i>	M.D.		Catonsville 28, Md.					
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/26/58	22c. NAME OF CEMETERY OR CREMATORIUM U. of M. Mortuary Board		22d. LOCATION (City, town, or county) Baltimore		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Aldeburgh		ADDRESS		24a. REC'D BY REGISTRAR AUG 6 '58	24b. REGISTRAR'S SIGNATURE Aldeburgh			



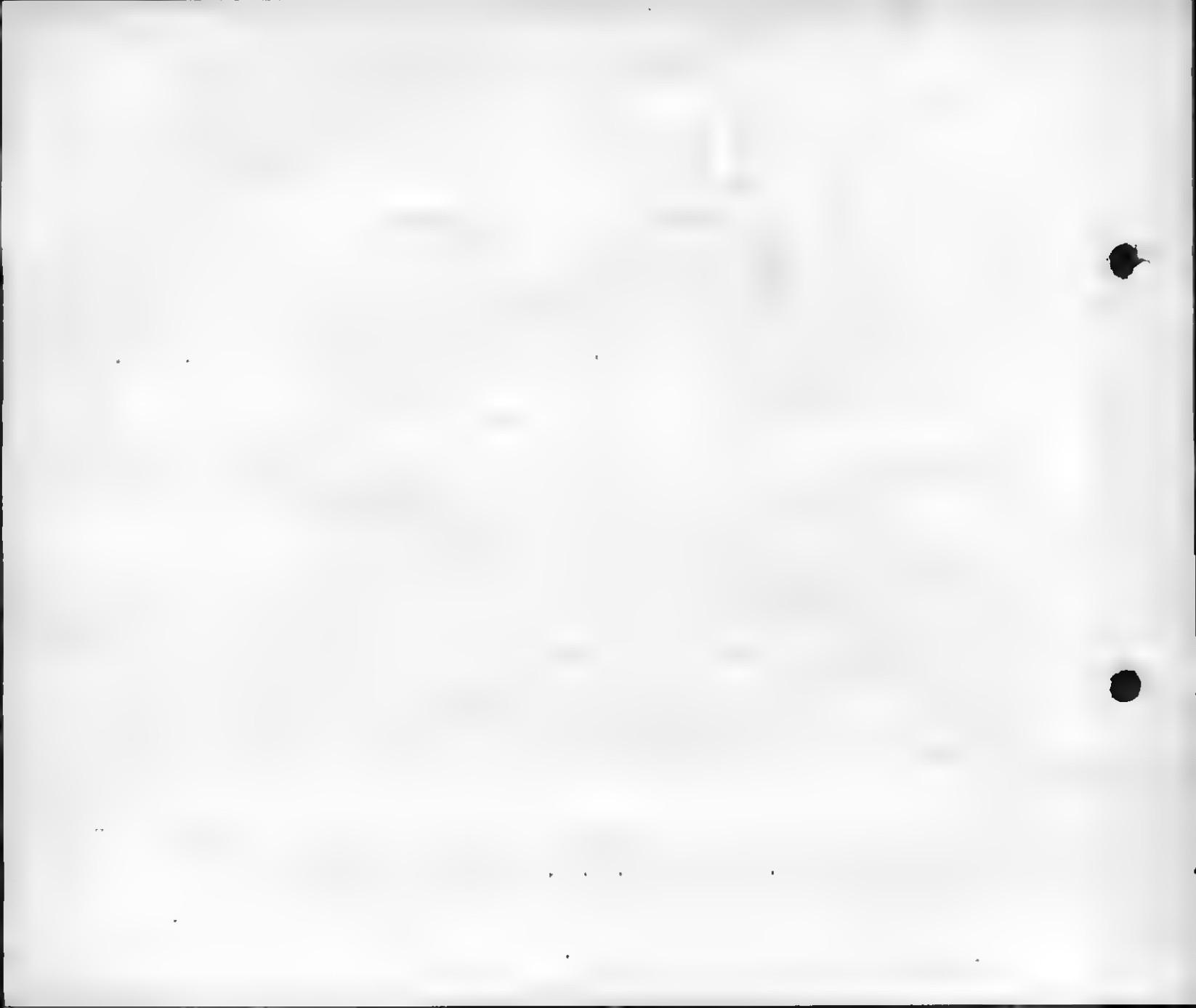
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07635

7653 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 7mths6dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 1111 Fifty-first Street	
3. NAME OF DECEASED (Type or print) Harry Eugene Cowan		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX male	5. COLOR OR RACE white	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 4, 1879		9. AGE (In years last birthday) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME William Cowan		14. MOTHER'S MAIDEN NAME Nonay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Record: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Generalized arteriosclerosis			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1958, to July 1, 1958, that I last saw the deceased alive on July 1, 1958, and that death occurred at 11:55 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Gertrude J. Fleischmann M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-1-58	
PHYSICIAN'S NAME (Type) Gertrude J. Fleischmann, M. D. Catonsville 28, Maryland			
22a. BURIAL CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 6/5/58	
22c. NAME OF CEMETERY OR CREMATORIUM George Washington Cemetery		22d. LOCATION (City, town, or county) Hyattsville Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.			
ADDRESS		24a. REC'D BY REGISTRAR JUL 7 '58	
24b. REGISTRAR'S SIGNATURE C. Lee			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07636

7654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN lb <i>74 days</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>602 WASHINGTON, AVE.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>					
3. NAME OF -DECEASED (Type or print)	First <i>Marie</i>	Middle <i>Anna</i>	Last <i>Row</i>				
4. DATE OF DEATH <i>July 25</i>	Month <i>JUL</i>	Day <i>25</i>	Year <i>1958</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 17 1884</i>				
9. AGE (In years last birthday) <i>75 1/2</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Business</i>					
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John J. Hudson</i>		14. MOTHER'S MAIDEN NAME <i>Sabelia Sull</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>416-18-0000</i>					
17. INFORMANT <i>F. G. Reginald Morrison, Bd.</i>		Address <i>18</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease, cerebral vascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>[b]</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>Six weeks</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month, Day, Year <i>July 25 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Rollin C Hudson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>July 25 1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7-27-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>GREENHILL CEM.</i>		22d. LOCATION (City, town, or county) <i>BERRYVILLE</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balt., Md.</i>		ADDRESS <i>4905 York Rd. Balt., Md.</i>		24a. REC'D BY REGISTRAR <i>JUL 29 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John C. Hudson</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



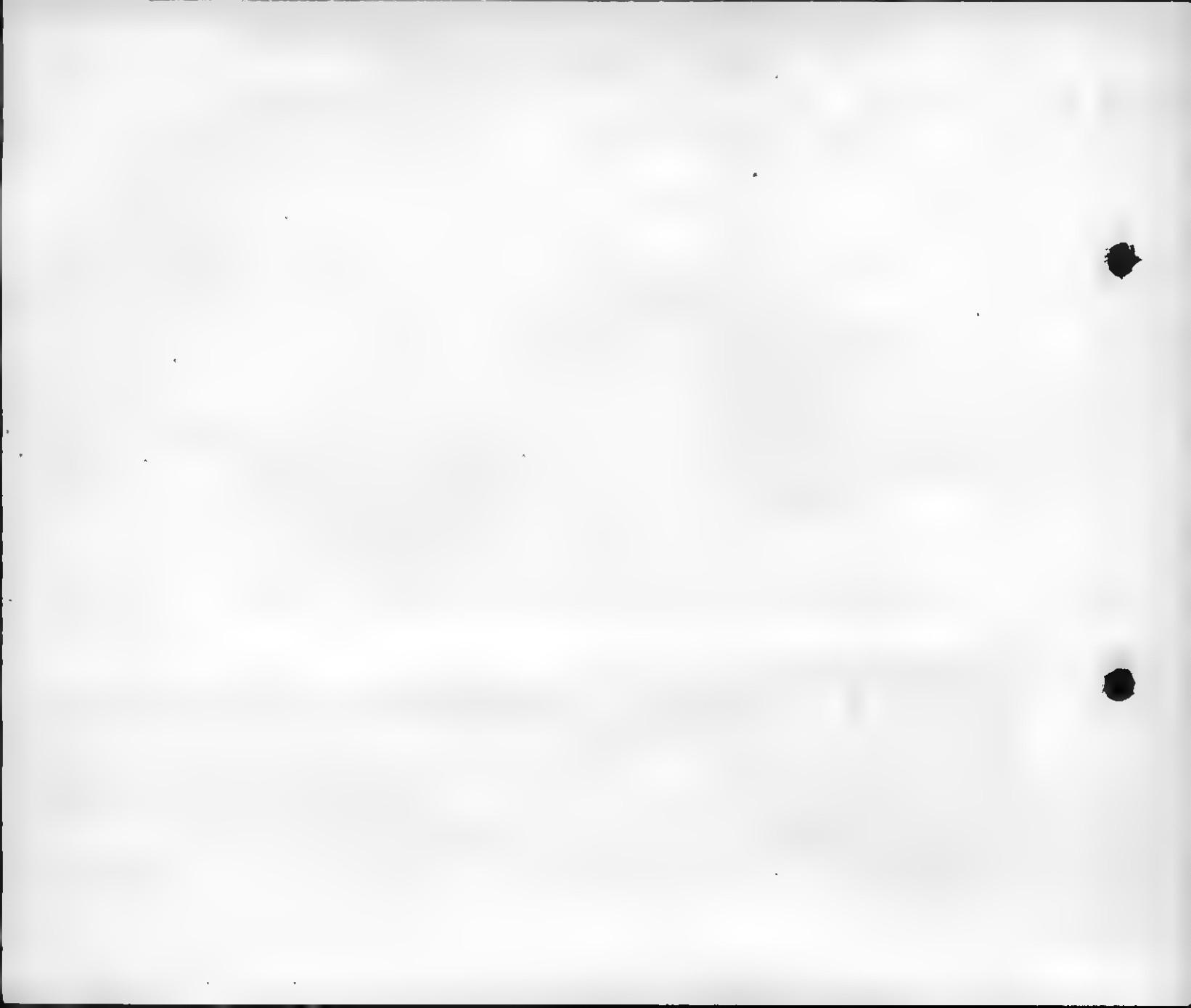
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7655

CERTIFICATE OF DEATH

Reg. Dist. No. 07637

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brighton Rural	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brighton, Baltimore County	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 6627 Brighton Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First John	Middle Cullen	4. DATE OF DEATH July 10
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner	11. BIRTHPLACE (State or foreign country) Wexford, Ireland
13. FATHER'S NAME John Cullen		14. MOTHER'S MAIDEN NAME Mary Coughlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Annastacia Cullen, 6627 Brighton Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		Coronary Occlusion - Bronchitis - chronic c - Gastro - chronic	
		INTERVAL BETWEEN ONSET AND DEATH 1 day 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 1, 1957, to JULY 10, 1958, that I last saw the deceased alive on JULY 10, 1958, and that death occurred at 3 A.M. from the causes and on the date stated above.		ADDRESS (Street, City or town, state) Randleman - Md DATE SIGNED 7/11/58	
ACTUAL SIGNATURE Thomas E. Wheeler, M.D.			
PHYSICIAN'S NAME (Type) Thomas E. Wheeler, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery
22d. LOCATION (City, town, or county) Pikesville 8, Md. (State)		22e. LOCATION (City, town, or county) Pikesville 8, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell - Gicksville, Md.		24a. ADDRESS	24b. REGISTRAR'S SIGNATURE
		DATE JULY 11, 1958	A. Bresnick



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07638

CERTIFICATE OF DEATH

Reg. Dist. No.

7656

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton (rural)		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton (rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shepperd Rd.		d. STREET ADDRESS Shepperd Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Philip	Middle Christopher	Last Curley	4. DATE OF DEATH 7-23-58	Month Year Day		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-22-1889	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY auto repair		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. E. Curley				14. MOTHER'S MAIDEN NAME Julia Friese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO. 220-09-9654		17. INFORMANT Philip C. Curley, Box 325, Rt. 1, White Marsh		Address Md. 2911	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>open</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
July 30 1958							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William Boster</i>				ADDRESS (Street, city or town, state) White Hall Rd. July 30, 1958			
DATE SIGNED July 30, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-26-58		22c. NAME OF CEMETERY OR CREMATORIUM St. James Episcopal		22d. LOCATION (City, town, or county) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks</i>		ADDRESS 622 York Rd., Towson, Md.		24a. REC'D BY REGISTRAR DATE JUL 28 '58		24b. REGISTRAR'S SIGNATURE <i>Albert Louch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
page 3 should be detached for use on the burial-transit permit. Then please give carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07639				
7657 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY BALTIMORE					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD					c. LENGTH OF STAY IN TB 20 days					d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First RAYMOND		Middle T	Last DALEY		4. DATE OF DEATH JULY 3 1958		Month JULY	Day 3	Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9-16-88		9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY RETAIL JEWELRY		11. BIRTHPLACE (State or foreign country) CHICAGO ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.								
13. FATHER'S NAME JERRY J DALEY					14. MOTHER'S MAIDEN NAME HELEN LAPPIN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES					16. SOCIAL SECURITY NO. 289-12-8343		17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MD		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH 10 DAYS				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA RIGHT LUNG														
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last DIETOX										UNKNOWN				
(b) ARTERIOSCLEROTIC HEART DISEASE										UNKNOWN				
(c) GASTRIC ULCERS										UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) VAH (State) MARYLAND					
21. I certify that Chien Wei Lan attended the deceased from June 13, 1958 , to July 3, 1958 , and that death occurred at 9:05 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED 7-1-58				
ACTUAL SIGNATURE Chien Wei Lan										M.D. VAH Fort Howard Maryland				
PHYSICIAN'S NAME (Type)		M.D. VAH Fort Howard Maryland								7-4-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-8-58		22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL				22d. LOCATION (City, town, or county) BALTIMORE		(State) MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight Inc. 6009 Harford Rd.		ADDRESS 6009 Harford Rd.								24a. REC'D BY REGISTRAR DATE JUL 8 '58		24b. REGISTRAR'S SIGNATURE Q. Cook		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7614

Item 2
7-2-58 et

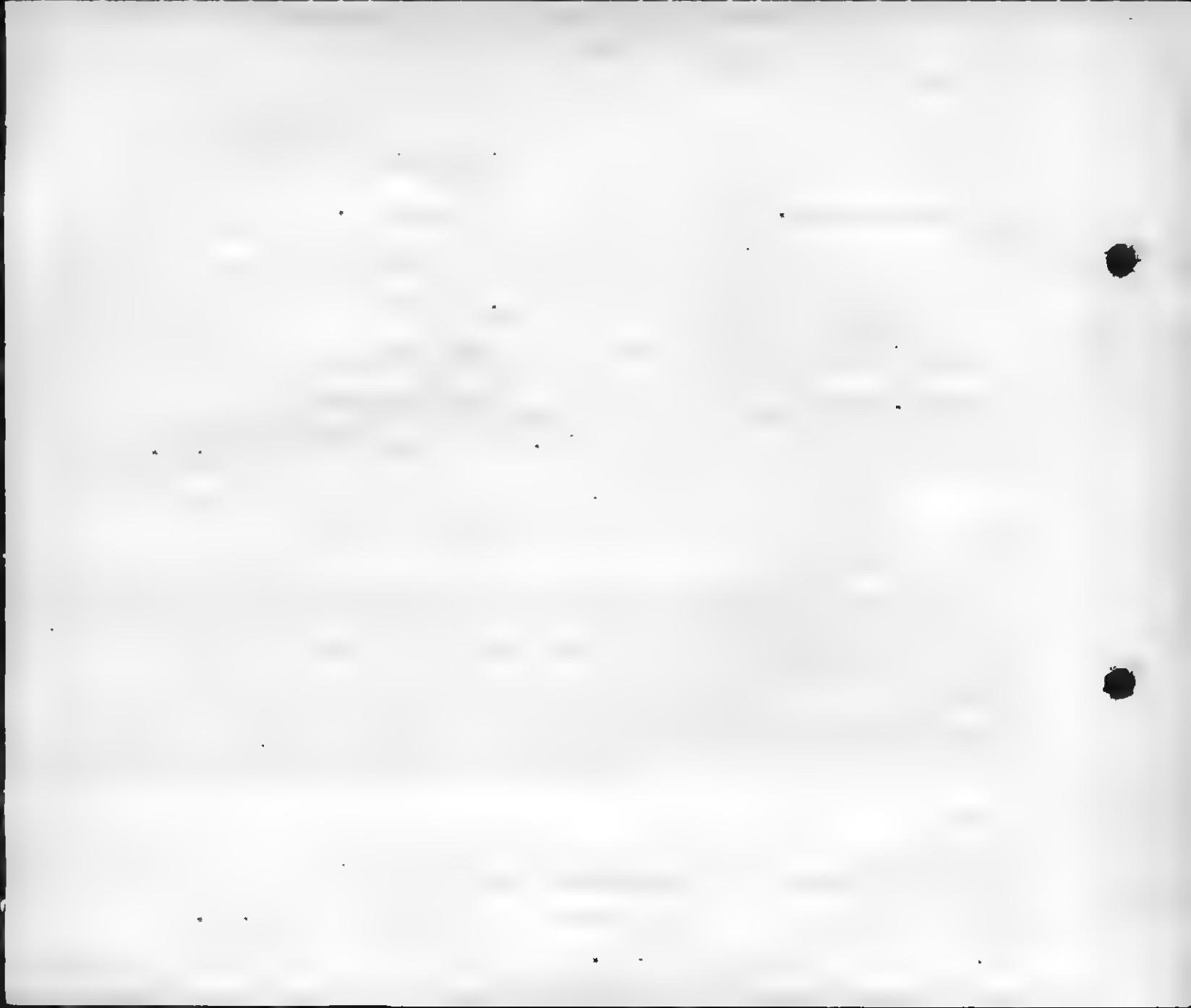
07641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		d. STREET ADDRESS <i>Old Frederick Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11 Dundalk Ave. (Private home)</i>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>ELIZABETH</i>	Last <i>DAVIS</i>	4. DATE OF DEATH <i>Dec. 30, 1878</i>	Month <i>Dec.</i>	Day <i>30</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 30, 1878</i>	9. AGE (In years last birthday) <i>79</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Maryland</i>	
13. FATHER'S NAME <i>James T. French</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Wolfington</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Miss. Mary Davis</i>		Address <i>Old Frederick Rd, Ellicott City, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyperensive CARDIOVASCULAR Renal disease</i>		DUE TO <i>44a</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Generalized Arterio sclerosis</i>		DUE TO <i>15 yrs</i>					
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchitis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Harrisonville</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>6/20</i> , 19 <i>58</i> , to <i>1/2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/30</i> , 19 <i>58</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jack C Collins</i> PHYSICIAN'S NAME (Type) <i>JACK C Collins</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7/7/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Family</i>		22d. LOCATION (City, town, or county) <i>Harrisonville, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. HIGGINBOTHOM</i>		ADDRESS <i>Ellicott City, Md.</i>	24a. REC'D BY REGISTRAR DATE JUL 7 1958		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

07640

7658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28	c. LENGTH OF STAY IN 1b 4 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home	d STREET ADDRESS 403 Hilton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GUILLERMINA De B. DALCOUR	First	Middle	Last
4. DATE OF DEATH July 1, 1958.	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 9, 1872 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) CUBA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME E.A. EUGENE DE BULLET	14. MOTHER'S MAIDEN NAME CARLOTA A. TRAUB		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. BENJ. WHITELEY 403 HILTON AVE	Address CATONSVILLE MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 6 Weeks	
1. <i>liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO		<i>Metastatic carcinoma of lungs</i>	
(c) DUE TO		<i>carcinoma of right breast</i> 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 16, 1958</i> to <i>July 1, 1958</i> , that I last saw the deceased alive on <i>June 20, 1958</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>George F. Urban M.D. 805 Frederick Ave 28 Md</i>	
ACTUAL SIGNATURE <i>George F. Urban</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>George F. URBAN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 3, 1958.	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Easton Sons Catonsville, 28 July</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 8 '58
			24b. REGISTRAR'S SIGNATURE <i>Albert L. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-trust permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7624 CERTIFICATE OF DEATH

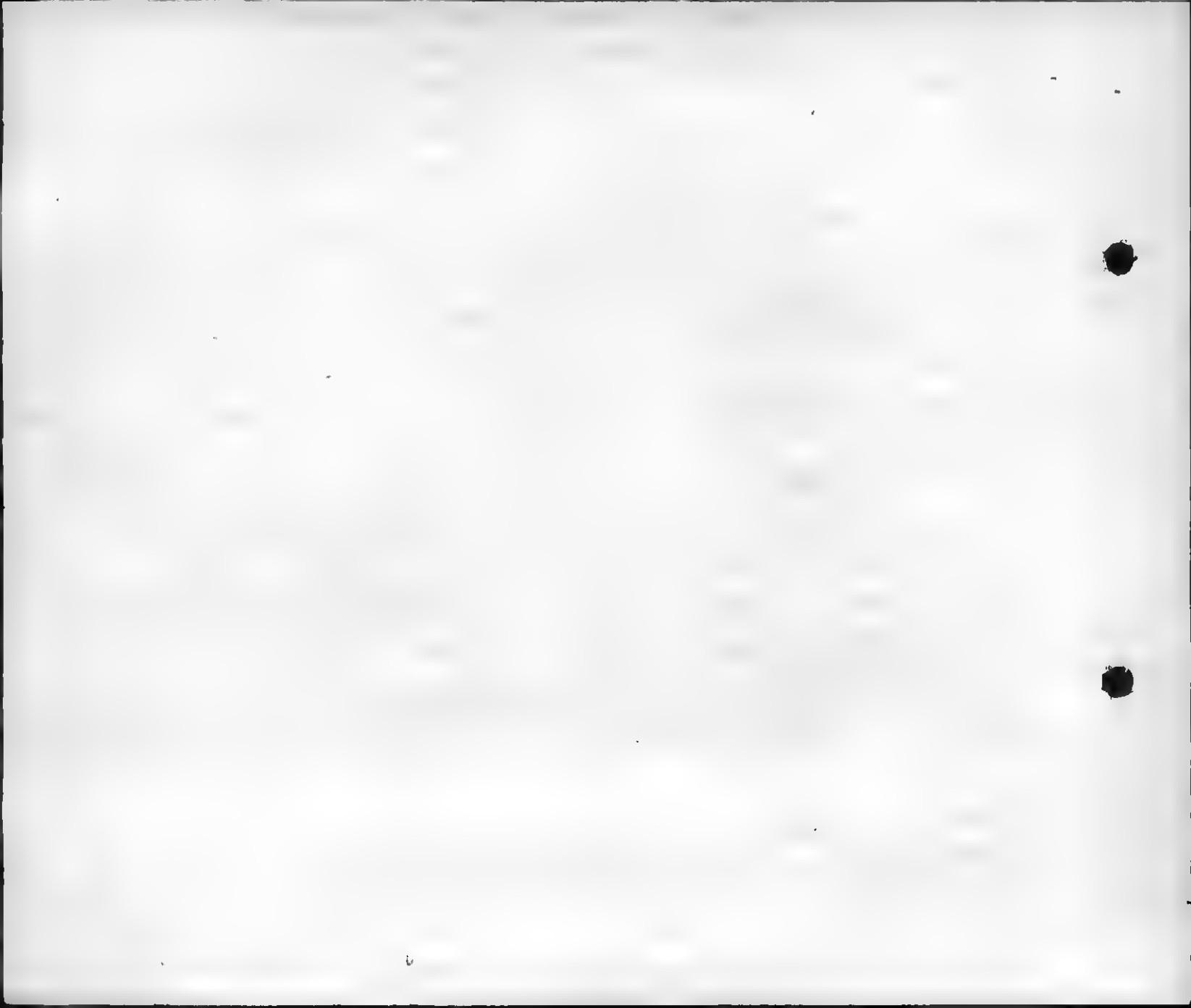
07642

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Item 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <i>Relay</i>		c. LENGTH OF STAY IN 1b <i>48 hr 30 min</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Relay Hill Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green belt, Maryland</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>Eduard</i>	Middle <i>Doneellan</i>
4. DATE OF DEATH <i>July 13 1958</i>		Last <i>1958</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/15/1875</i>
9. AGE (In years from birthdate) <i>83 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Newspaper</i>	11. BIRTHPLACE (State or foreign country) <i>New Orleans La United States</i>
12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
13. FATHER'S NAME <i>Martin Doneellan</i>			
14. MOTHER'S MAIDEN NAME <i>Amelia Riggs Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) (If yes, give name or date of service) <i>Unknown</i>			
16. SOCIAL SECURITY NO. <i>Unknown</i>			
17. INFORMANT <i>Mary L. Doneellan - 18C - Crescent Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Failure</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Myocardial insufficiency</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis</i>			
Many years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>July 13, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Colmar Manor, Prince George's Co., Md.</i>
21. I certify that I attended the deceased from <i>July 11, 1958</i> , to <i>July 13, 1958</i> , that I last saw the deceased alive on <i>July 13, 1958</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7/13/58</i>			
ACTUAL SIGNATURE <i>Lewis P. Gundry</i>		DATE SIGNED <i>7/13/58</i>	
PHYSICIAN'S NAME (Type) <i>Lewis P. Gundry MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/16/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Foothillswood Cemetery</i>
22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Prince George's Co., Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Riverdale Md.</i>		24a. REC'D BY REGISTRAR DATE <i>July 15 1958</i>	24b. REGISTRAR'S SIGNATURE <i>D. H. Smith</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

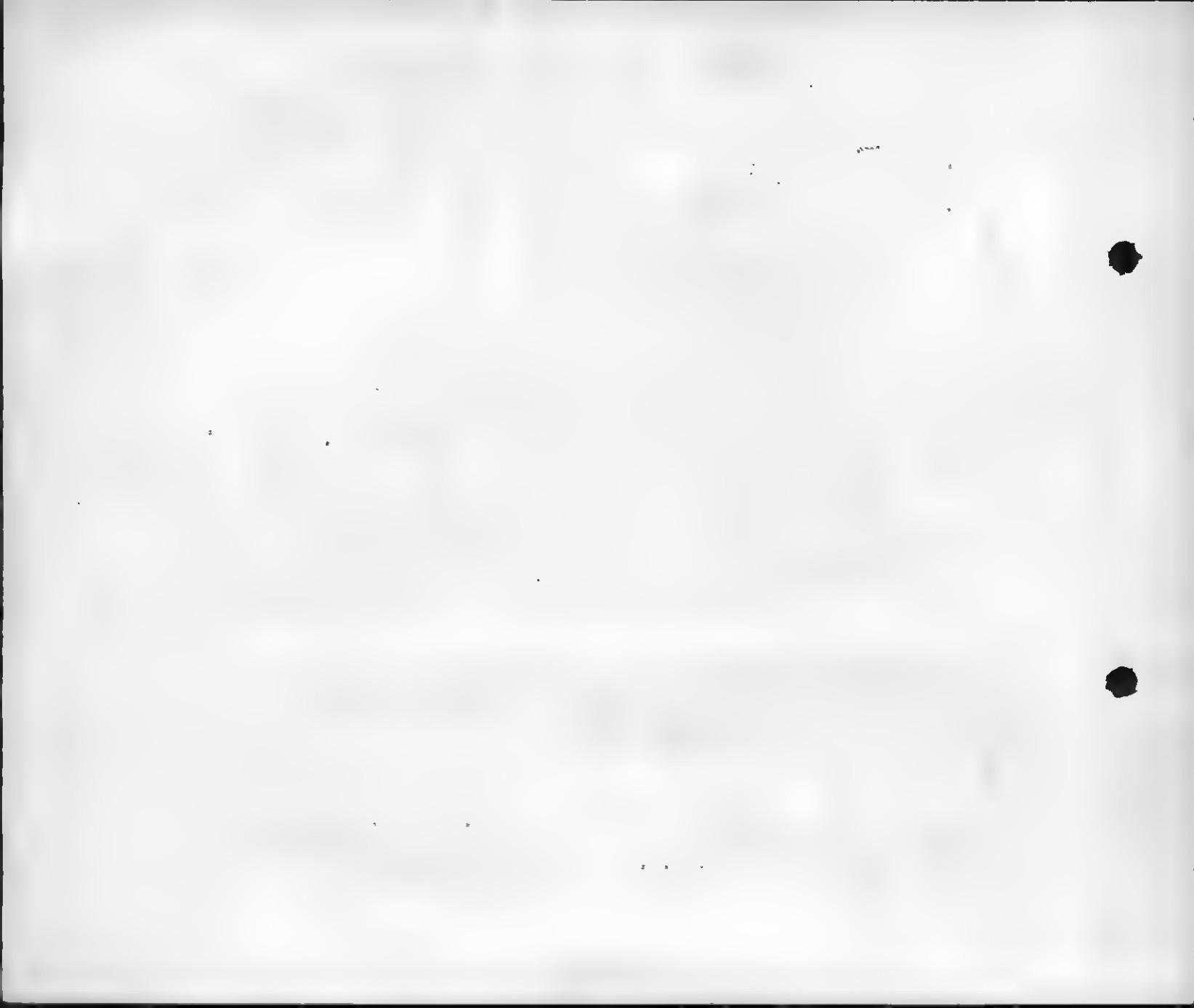
7659

CERTIFICATE OF DEATH

07643

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE Co.		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXENHILL		d. STREET ADDRESS 2403 SOUTHERN AVE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JEREMIAH		First	Middle	Lost	4. DATE OF DEATH DOWNNEY	Month 7	Day 12	Year 1958
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-95	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 12	Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY YELLOW-CAB		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C., U.S.A.		12. CITIZEN OF WHAT COUNTRY Cathleen S. Lynn GARRON		
13. FATHER'S NAME DENNIS J. DOWNEY		14. MOTHER'S MAIDEN NAME DOROTHY G. T. GARRON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. WNT NAVF 578-07-1054		17. INFORMANT Hospital Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UTEX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) COR PULMONALE DUE TO (c) EMPHYSEMA						INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1-15 , 19 57 , to 7-12 , 19 58 that I last saw the deceased alive on 7-12 , 19 58 , and that death occurred at 6:23 AM , from the causes and on the date stated above. ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland						ADDRESS (Street, city or town, state) DATE SIGNED		
PHYSICIAN'S NAME (Type) William Newcomer, M.D.				Superintendent				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-1958		22c. NAME OF CEMETERY OR CREMATORIAL McClintock		22d. LOCATION (City, town, or county) Washington		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly, Wash. D.C.		ADDRESS 131-111 S.W. 18		24a. REC'D BY REGISTRAR DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE Allie Smith		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07644

7615 CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAIN WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Frances Drozdowski (Doskey)		July 3, 1958	
3. PLACE OF DEATH A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence A STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION		B. COUNTY before admission BALTIMORE	
6848 Duluth Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1435 Carswell St.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Widowed	Oct. 18, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 77	
10B. KIND OF BUSINESS OR INDUSTRY		10. MONTHS: Days Hours: Min.	
13. FATHER'S NAME John Kramer		11. BIRTHPLACE (State or foreign country) Germany	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen Rousculp	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 155. II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		ADDRESS 6848 Duluth	
		INTERVAL BETWEEN ONSET AND DEATH Unknown	
19. DATE OF OPERATION April 1958		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. TIME (Month) (Day) (Year) (Hour) OF INJURY		21B. MAJOR FINDINGS OF OPERATION In Gall Bladder	
		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from May 1st, 1958, to July 3, 1958, that I last saw the deceased alive on July 1st, 1958, and that death occurred at 5:10 p.m., from the causes and on the date stated above.		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE John E. Fissner		23B. ADDRESS 101 Eastern Avenue	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1958	
24C. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus		24D. LOCATION (City, town, or county) Dundalk Ave. Md.	
DATE RECEIVED BY LOCAL REGISTRAR JULY 6 - 1958		REGISTRAR'S SIGNATURE Huntington Village	
		25. FUNERAL DIRECTOR John J. Duda 2829 Hudson St. 24 Md.	
		ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7660

CERTIFICATE OF DEATH

07645
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 517 S. Bouldin Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle J.	Last DROTER	4. DATE OF DEATH July 11	Month July	Day 11	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1896	9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nicheal Droter				14. MOTHER'S MAIDEN NAME Mary Kuzama				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO. 216-10-1983	17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUODENAL ULCER (c) ARTERIOSCLEROTIC HEART DISEASE-CORONARY SCLEROSIS								
INTERVAL BETWEEN ONSET AND DEATH SEVERAL MINUTES UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUODENAL ULCER - 18 YEARS								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) Maryland	(State) Md.
21. I certify that I attended the deceased from JULY 7, 1958 , to JULY 11, 1958 , that I last saw the deceased alive on JULY 7, 1958 , and that death occurred at 6:10 p.m. from the causes and on the date stated above								
ADDRESS (Street, city or town, state) MD VAH FORT HOWARD MARYLAND								
DATE SIGNED 7-12-58								
ACTUAL SIGNATURE <i>Jasper L. Van Avery</i>		M.D. VAH FORT HOWARD MARYLAND						
PHYSICIAN'S NAME (Type) JASPER L VAN AVERY		7-12-58						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/15/58		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Bright, Inc.		ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR Jul 14 '58		24b. REGISTRAR'S SIGNATURE Allie Cook		

W.H. 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07646

7661

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE		d. STREET ADDRESS BOX 314	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BIRD RIVER BEACH				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EARLE	Middle IRENUS	Last EDER	4. DATE OF DEATH July 20 1958	Month July	Day 20	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1896	9. AGE (In years (last birthday) 62 yrs.)	IF UNDER 1 YEAR Months 62	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY ELEC. CONTRACTOR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD J. EDER				14. MOTHER'S MAIDEN NAME AMELIA TOLLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 217-01-2947		17. INFORMANT FLORA REINHOLDT		Address Box 314 Chase	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastrointestinal hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Chronic Nephritis</i> DUE TO (c) <i>Pulmonary Encephalitis</i> INTERVAL BETWEEN ONSET AND DEATH 5-10 mins							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 1958 , to 7/20 1958 , that I last saw the deceased alive on 7/18 1958 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 434 Eastern Ave Parkville, Md. DATE SIGNED 7/21/58							
ACTUAL SIGNATURE <i>J. PLATT, M.D.</i> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Maryland Memorial Park Parkville, Md.		22d. LOCATION (City, town, or county) (See)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons Towson 4, Md.				ADDRESS Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JUL 22 '58	
						24b. REGISTRAR'S SIGNATURE Allied Health	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page _____
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07647

Reg. Dist. No

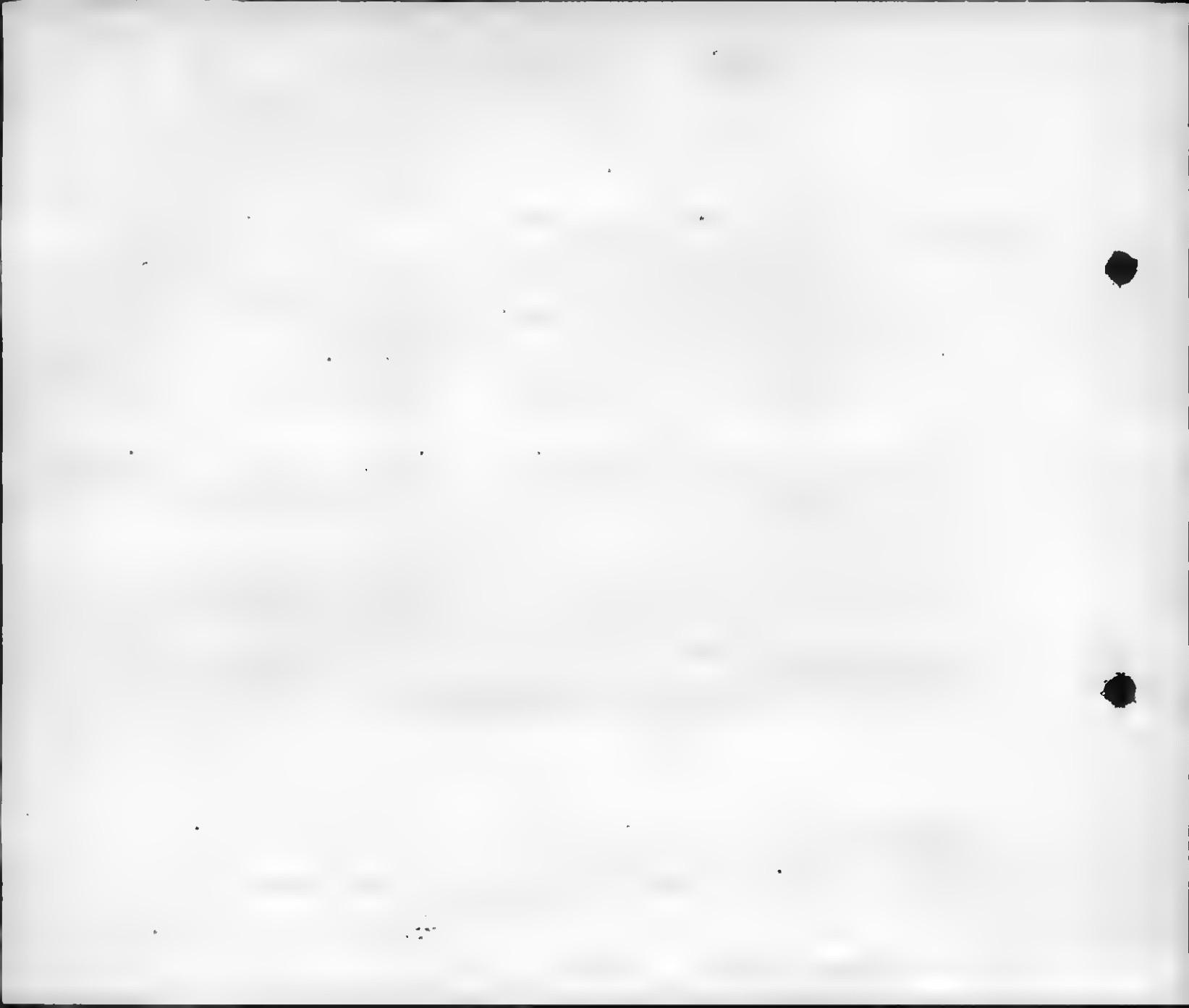
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville		c. LENGTH OF STAY IN lb 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baynesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8708 Eddington Rd.			d. STREET ADDRESS 8708 Eddington Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Female		First Mary	Middle Ann	Emge	Lost 4. DATE OF DEATH Month July Day 11, Year 1958
5 SEX Female		6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH Dec. 19, 1911	9 AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armature Winder		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) Hancock, Md.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Harvey Mellott			14. MOTHER'S MAIDEN NAME Angeline Landers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-18-8873		17. INFORMANT Mr. Albert E. Emge 8708 Eddington Rd. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 110 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 27 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased <u>1925</u> am. <u>1958</u> to <u>1958</u> that I last saw the deceased alive on <u>7/1/58</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, State)					
ACTUAL SIGNATURE <u>Bennett A. Stoen</u> DATE SIGNED <u>7/4/58</u>					
PHYSICIAN'S NAME (Type) Bennett A. Stoen					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park	
23. FUNERAL DIRECTOR'S SIGNATURE Cassabur Funeral Home		ADDRESS 7401 Belair Rd.		22d. LOCATION (City, town, or county) Baltimore Md.	
				24a. REGD BY REGISTRAR JULY 6 1958	
				24b. REGISTRAR'S SIGNATURE Alt. Search	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial. See page 72 for details.

VS A15 (4)
15M 10/52



7663 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY
BALTO. ROSEDALE		BALTO.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	8366 Pulaski Hwy.		
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
MOLLIE A. FICK			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
F.	W	WIDOWED	8/8/1873
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
84 yrs.	HOUSEWIFE, AT HOME	MD.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
JAMES GARRETT	BANNAY CORNS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	18. MEDICAL CERTIFICATION
(If Yes, give war or dates of service)		Russell Guy 8366 Pulaski Hy.	Acute Cardiac Failure Arterio-arteritis Heart Disease
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, DUE TO GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	INTERVAL BETWEEN ONSET AND DEATH 8 days		
(A) (B) (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MED CAL EXAMINER)	21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
	HOME	1118 S. East Ave Balto 24 Md	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? SLIPPED + FELL IN HOME	
JULY 16 1958 5P M.			
22. I hereby certify that I attended the deceased from APRIL 1953 to JULY 27 1958, that I last saw the deceased alive on JULY 27 1958, and that death occurred at 1220 AM, from the causes and on the date stated above.			
SIGNATURE Joseph Kucel	ADDRESS (Street, city, town, state) 108 S. TAYLOR AVE BALTO. Co. MD. DATE SIGNED M.D. 1347011 7/29/58		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
BURIAL	7/26/58	OAK LAWN	BALTO. Co. MD.
24 REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
DATE JUL 28 '58	Reh. - mack	C.F. Hoffmann 3218 Hudson St.	

Fig. 2. *Endothia craterii* (Berk.) Sacc.
var. *leptophloeus* - new var.

1946-1947 2 8-19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7664 CERTIFICATE OF DEATH

Reg. Dist. No. 07649

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>31 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		d. STREET ADDRESS <i>30 Overbrook Rd.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>30 Overbrook Rd.</i>				d. STREET ADDRESS <i>30 Overbrook Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Minnie C. Fischer</i>		First	Middle	Last	4. DATE OF DEATH <i>7/20/58</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/7/49</i>	9. AGE (In years less birthday) yrs. <i>8</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>	13. Min 14. Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Karl Hoerning</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Hanke</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charlotte Gordreich</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3da.</i>		
DUE TO <i>Hypertension</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO <i>Dr. Hypertension Cardi-Vascular Disease</i>				15yr.		
(c)								
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 6209 Frederick Ave.</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		
alive on _____		alive on _____		alive on _____		alive on _____		
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>		DATE SIGNED <i>7-21-58</i>				
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/24/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>London Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Don</i>		ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Antonie</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use on burial-transit permit. Then please remove carbon-papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7665

CERTIFICATE OF DEATH

Reg. Dist. No.

07650

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE Where deceased lived If institution, Residence before admission a. STATE Maryland b. COUNTY Prince George's Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 13yr3mths1ldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland Fort Richmond	
3. NAME OF DECEASED (Type or print) George W. Fitzgerald		d. STREET ADDRESS Sacred Heart Home County Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX male white		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 9, 1901		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George W. Fitzgerald		14. MOTHER'S MAIDEN NAME Elizabeth Schultz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Acute myocardial infarction	
DUE TO (c)		Coronary thrombosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1958, to July 9, 1958, that I last saw the deceased alive on July 9, 1958, and that death occurred at 8:15 p.m., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler, M. D. SPRING GROVE STATE HOSPITAL 7-10-58			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/58	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gusche Son Hyattsville Md		24a. REC'D BY REGISTRAR DATE JUL 14 '58	
24b. REGISTRAR'S SIGNATURE C. W. Eastman			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be retained by the hospital or attending physician.

page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

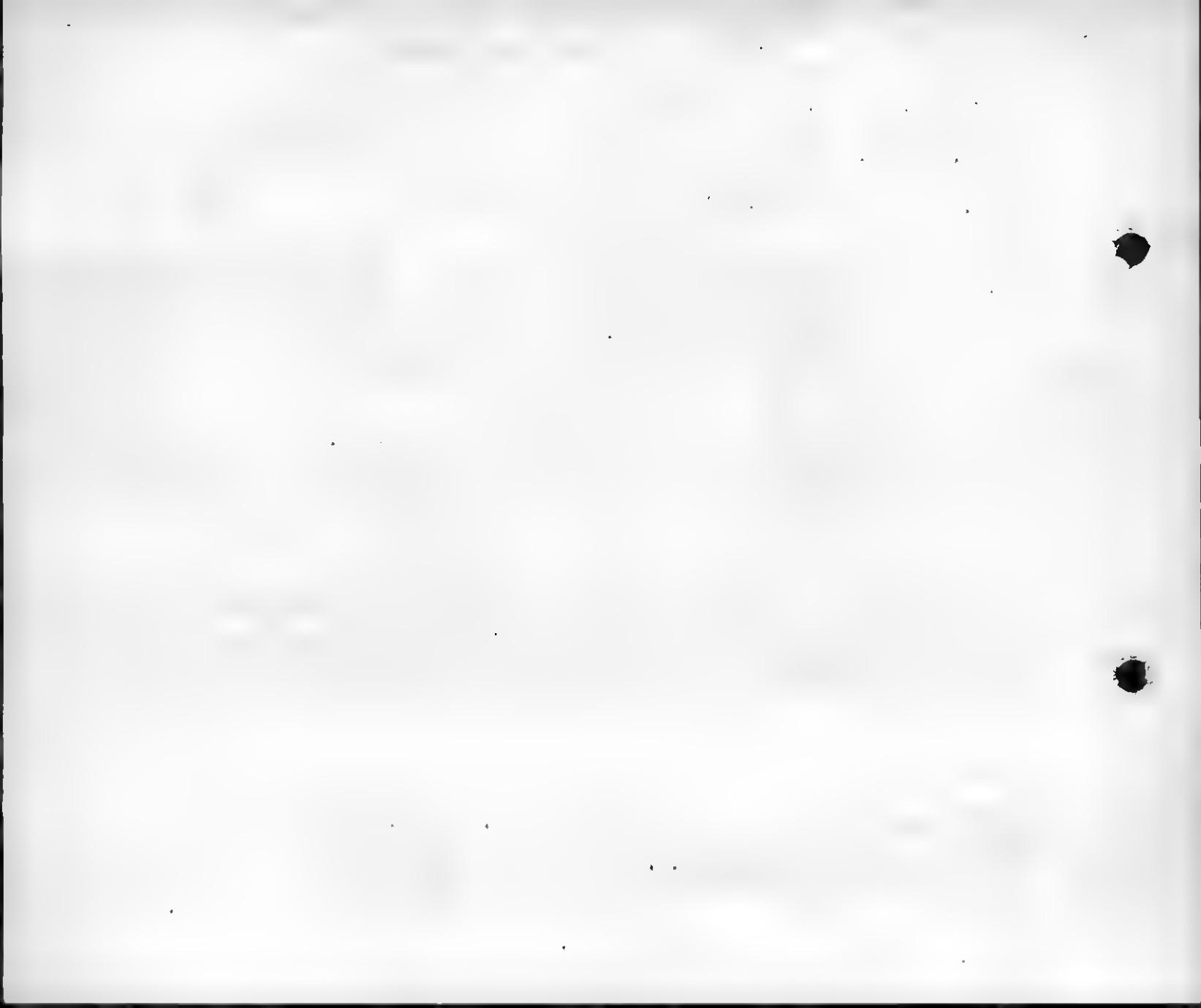
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7666 CERTIFICATE OF DEATH

07651

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER		d. STREET ADDRESS 6115 Osborn Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HENRY	Middle CLAYTON	Last FLEMING	4. DATE OF DEATH July	Month 6	Day 1958	Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7. 12. 07	9. AGE (in years (last birthday) 50 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Days 0	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY J.S.A.		
13. FATHER'S NAME ALONZO LEE FLEMING		14. MOTHER'S MAIDEN NAME SARAH ELLEN COSTELLO						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG INTERVAL BETWEEN ONSET AND DEATH 7 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) METASTASIS OF CARCINOMA TO VERTEBRAE								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —	
21. I certify that I attended the deceased from 5 - 15 , 19 58 to 7 - 6 , 19 58 , that I last saw the deceased alive on 7 - 6 , 19 58 , and that death occurred at 2:10 P.M. from the causes and on the date stated above								
ACTUAL SIGNATURE William Newcomer				ADDRESS (Street, city or town, state) Mt. Wilson, Maryland				
DATE SIGNED —								
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/58		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 9 '58		
						24b. REGISTRAR'S SIGNATURE Alfred J. Schaefer		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7667

CERTIFICATE OF DEATH

07652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester, Virginia		d. STREET ADDRESS 112 N. Washington St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Middle Bowie	Last FLOOD	4. DATE OF DEATH July 31 1958	Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1870 Sept. 23, 87	9. AGE (In years lost birthday) 87 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Edwgnard Contee Johnson				14. MOTHER'S MAIDEN NAME Kate Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. E. Ridgely Simpson, 1719 Circle Rd.		Address	
No		No					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							
443x DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1403 Park Ave.	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from June 1958 to July 31, 1958, that I last saw the deceased alive on July 31, 1958, and that death occurred at 2:45 PM, from the causes and on the date stated above.							
ACTUAL W.H. Woody							
PHYSICIAN'S NAME (Type) W.H. Woody							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/3/58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hebron		22d. LOCATION (City, town, or county) Winchester, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson Inc. Towson, Md.							
ADDRESS 1050 York Rd.				24a. REC'D BY REGISTRAR DATE 8/3/58		24b. REGISTRAR'S SIGNATURE A. Cook	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7668 CERTIFICATE OF DEATH

07653

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as a burial-transit permit. Then please remove carbon-paper page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

1. PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 25, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. STREET ADDRESS 913 First Street			
3. NAME OF DECEASED (Type or print) First Donald		4. DATE OF DEATH Last Foster Month 7 Day 16 Year Year 19 58			
5. SEX Male		6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/24/52			
9. AGE (In years last birthday) 5 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Sherman Hoover Foster		14. MOTHER'S MAIDEN NAME Bertha Anna Hullihen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.			
17. INFORMANT Rosewood Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Failure of vital functions (respiration)</i> INTERVAL BETWEEN ONSET AND DEATH <i>325.5</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>Hag-Sachs disease</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Manh. Day. Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/3/56, 19, to 7/16/58, 19, that I last saw the deceased alive on 7/16/58, 19, and that death occurred at _____, M, from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Rich. Lindenbergs (Patz.)</i> M.D. DATE SIGNED <i>7/16/58</i>					
PHYSICIAN'S NAME (Type)		<i>Rich. Lindenbergs (Patz.) 700 Fleet Street Bldg. No. 2</i>			
22a. BURIAL, Cremation, REMOVAL (Specify) <i>7-18-58 (Eduard Kline)</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>See Eddy - Funeral Home.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 18 '58	
				24b. REGISTRAR'S SIGNATURE <i>Webber</i>	

卷之四



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7669 CERTIFICATE OF DEATH

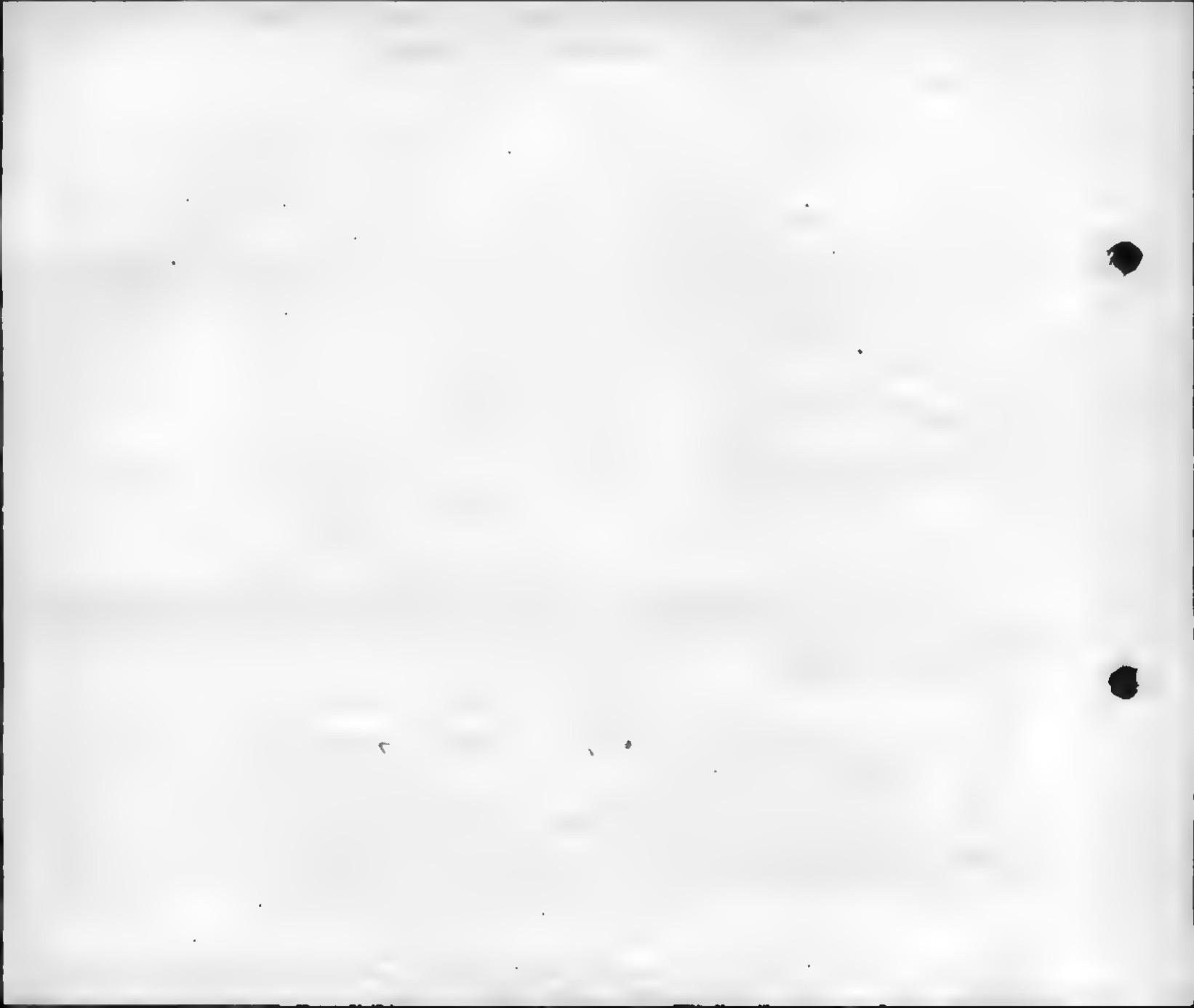
Reg. Dist. No.

07654

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE	b. COUNTY		
Baltimore				Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
House in lines		2317 Farringdon Rd		Baltimore			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
SAMUEL		-	FRIEDMAN	7	25 1958		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (last birthday) yrs.)	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
Male		white	WIDOWED <input checked="" type="checkbox"/>	4-15-1890	68		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
retired		Furniture		Washington DC		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Benjamin		Annie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
(If yes, give war or dates of service)				Living Weingrad-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY THROMBOSIS				1 wk.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		CEREBRAL THROMBOSIS				3 yrs	
DUE TO (b)		GENERALIZED ARTERIOSCLEROSIS				10 yrs	
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Norman R. Kleiman, M.D. 3803 Edmondson Ave				DATE SIGNED 7/16/58	
PHYSICIAN'S NAME (Type)		NORMAN R. KLEIMAN					
22a. FUNERAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		
Burial		7-27-58	B'nai Israel		Balto Md		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Jack Lewis Jr.		2100 Eutaw Pl		JUL 29 '58		John Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be retained until the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14

VS. A155
5M 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7670 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07655

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clementon

c. LENGTH OF STAY IN TB

Two 8 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Spring Grove State Hosp

3. NAME OF
DECEASED
(Type or print)

Alpha Edgar Friend

First

Middle

Last

3. SEX

m

w

6. COLOR OR RACE

7. MARRIED
 NEVER MARRIED

8. DATE OF BIRTH

May 24, 1891

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Paper hanger

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Indiana

USA

13. FATHER'S NAME

Edward Friend

14. MOTHER'S MAIDEN NAME

Terry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Miss Mary Friend w/ Son Ed at
Address 7221

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

Cadence insufficiency

arterio sclerotic heart disease

Generalized arterioclerosis

fracture Left femur accident

MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Day, Year

7:30 a.m. June 1, 1958

20d. INJURY OCCURRED

While Not while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20g. EXTERNAL CAUSE WAS
PRIMARY CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Fell on floor coming from dining room

19. WAS AUTOPSY
PERFORMED?
YES NO

YES

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my

opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

GEO. S. M. KIEFFER M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 9/58

22c. NAME OF CEMETERY OR CREMATORY

Baltimore National

22d. LOCATION (City, town, or county) (State)

Baltimore 29, Md

23. FUNERAL DIRECTOR'S SIGNATURE

W. T. K. Funeral Directors

4101 Edmondson Ave

ADDRESS

DATE

24a. REC'D BY REGISTRAR JUL 8 '58

REGISTRAR'S SIGNATURE

Alt. eam



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7671 CERTIFICATE OF DEATH

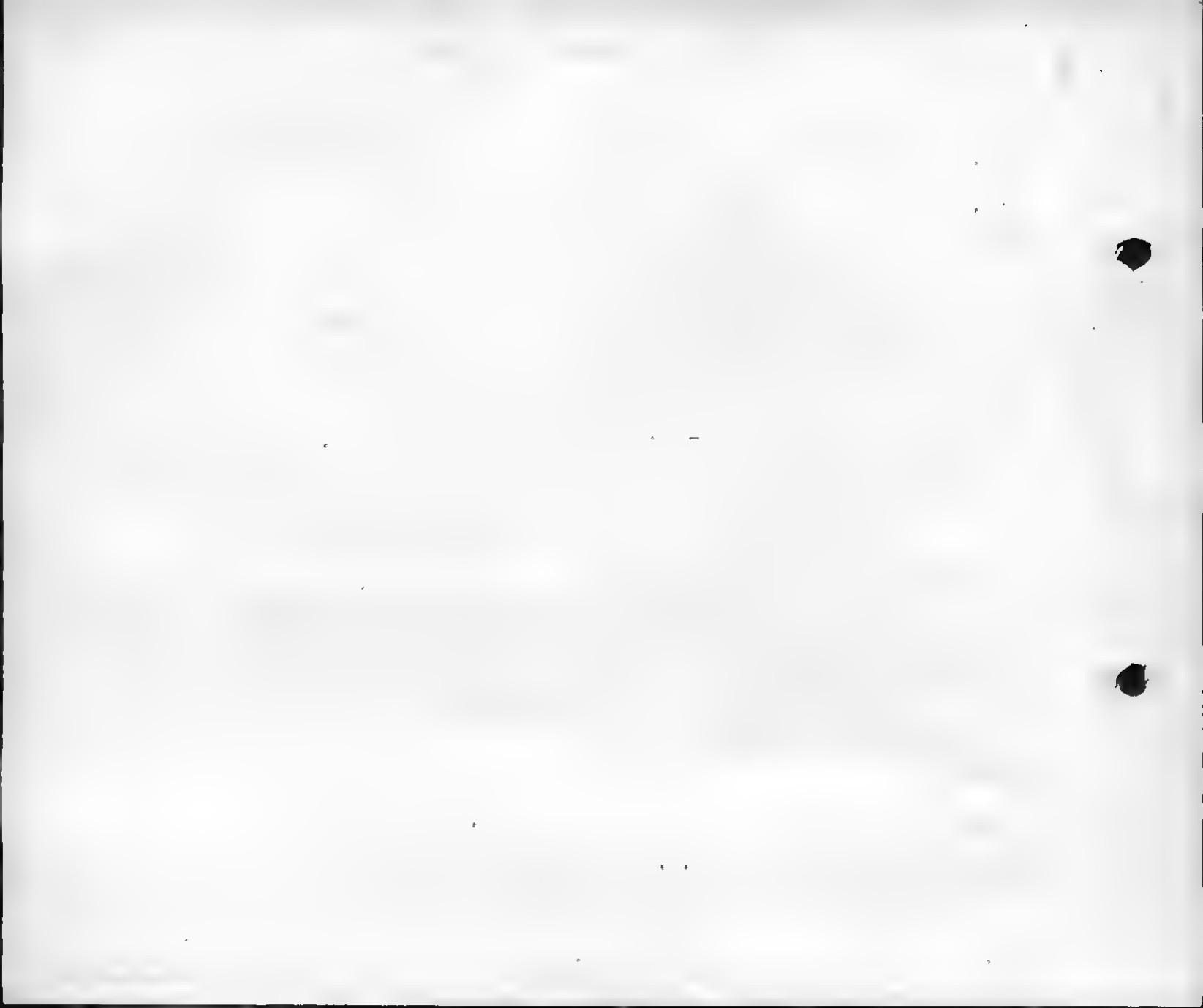
07656
32

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institutional, Residence before admission] a. STATE MARYLAND		b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LUTHERVILLE					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS RIDGELY ROAD		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JAMES	Middle DANIEL	Last GALLIGHER	4. DATE OF DEATH July	Month 25	Day Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-18	9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME DANIEL GALLIGHER		14. MOTHER'S MAIDEN NAME MARY JOSEPHINE McCARTHY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-01-3805		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 002 X		DUE TO COP PULMONALE				INTERVAL BETWEEN ONSET AND DEATH 46 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) PULMONARY TUBERCULOSIS		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EMPHYSEMA, PERICARDITIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —
21. I certify that I attended the deceased from 9-21 - 1958 , to 7-25 - 1958 , that I last saw the deceased alive on 7-25 - 1958 , and that death occurred at 6:25A.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) —		DATE SIGNED —	
ACTUAL SIGNATURE William Newcomer		M.D.		Mt. Wilson, Maryland					
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 7-28-58		22c. NAME OF CEMETERY OR CREMATORIUM Middletown Meth. Epis.		22d. LOCATION (City, town, or county) Freeland, Maryland		(State) —	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Rd. Towson		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 29 '58		24b. REGISTRAR'S SIGNATURE Elle couch			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PHM-5, may be used as a burial-transit permit. File pages 1 and 2 with the Board of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 16 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 218 Ridge Ave.		d. STREET ADDRESS 218 Ridge Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RICHARD		First	Middle
		Morrell	GOETZ
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH 9-29-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY auto parts	
10c. BIRTHPLACE (State or foreign country) Penn.		11. AGE (In years last birthday) 49 yrs	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lloyd Goetz	14. MOTHER'S MAIDEN NAME Beulah Morrell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 173-12-1952	17. INFORMANT Mabel P. Goetz, 218 Ridge Ave., Towson 4,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intra-cranial Hemorrhage 330 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		DATE SIGNED 7/31/58	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-58	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Prospect
23. FUNERAL DIRECTOR & STAFF NAME Brooks Funeral Service		22d. LOCATION (City, town, or county) Brackenridge, Penn.	(State)
		24a. REC'D BY REGISTRAR A. L. Sauch	24b. REGISTRAR'S SIGNATURE
		DATE AUG 4 '58	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item #13 - 7/16/58 - mb										
7673 CERTIFICATE OF DEATH										
Reg. Dist. No. 07658										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Towson					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road					d. STREET ADDRESS / Glenarm Road			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Sister Mary	Middle Lucille	Last Gorman	4. DATE OF DEATH	Month JULY	Day 10	Year 1958		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1889	9. AGE (In years last birthday) 6 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Roxbury, Mass			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Gorman					14. MOTHER'S MAIDEN NAME Anna Taaffe					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.			17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Metastasis DUE TO (c) Carcinoma of the Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4.1 X										INTERVAL BETWEEN ONSET AND DEATH 72 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Towson		(County) Baltimore		(State) Md.
21. I certify that I attended the deceased from April 1952 to July 1958, that I last saw the deceased alive on July 6, 1958, and that death occurred at 130 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles F. O'Donnell M.D.</i> ADDRESS (Street, city or town, state) Charles F. O'Donnell M.D. 7501 York Road Towson 4, Md. DATE SIGNED										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-17-58		22b. DATE THEREOF 901 S. CONKLING ST.		22c. NAME OF CEMETERY OR CREMATORIAL VILLA MARIA CEM. NOTCH CLIFF NR Towson		22d. LOCATION (City, town, or county) Baltimore		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles F. O'Donnell</i>		ADDRESS 901 S. CONKLING ST. BALTIMORE, MD.		24a. REC'D BY REGISTRAR JUL 14 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. L. Smith</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7674

CERTIFICATE OF DEATH

07659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. INFO. 1206 Edmonson Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
f. STREET ADDRESS 1206 Edmonson Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle Claye	Last Grant
4. DATE OF DEATH 7-16-58	Month 7	Day 16	Year 58
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1897
9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blender	14. KIND OF BUSINESS OR INDUSTRY De-Nut Co.	15. BIRTHPLACE (State or foreign country) Md.	16. CITIZEN OF WHAT COUNTRY?
17. FATHER'S NAME Charles T. Grant	18. MOTHER'S MAIDEN NAME Honore E. Fairell	19. ADDRESS 1206 Edmonson Ave.	
20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	21. SOCIAL SECURITY NO. 215-10-2125	22. INFORMANT Laura V. Grant	
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) DUE TO } (c) DUE TO Coronary Artery Atherosclerosis.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Auricular Fibrillation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 24c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		
24d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	24e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 24f. (City or town) (County) (State) 56 7/16/58		
25. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 7/3/58 from the causes and on the date stated above ACTUAL SIGNATURE W. E. McGrath ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) W. E. McGrath DATE SIGNED 1303 Frederick Rd Catonsville Md 7/7/58			
26. BURIAL, CREMATION, RE- MOVAL (Specify) Burial	27. DATE THEREOF 7-19-58	28. NAME OF CEMETERY OR CREMATORIUM Meadow Ridge Cem.	29. LOCATION (City, town, or county) Elkridge, Md.
30. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		31. ADDRESS 4107 Wilkins Ave.	32. REC'D BY REGISTRAR DATE JUL 21 58
			33. REGISTRAR'S SIGNATURE W. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

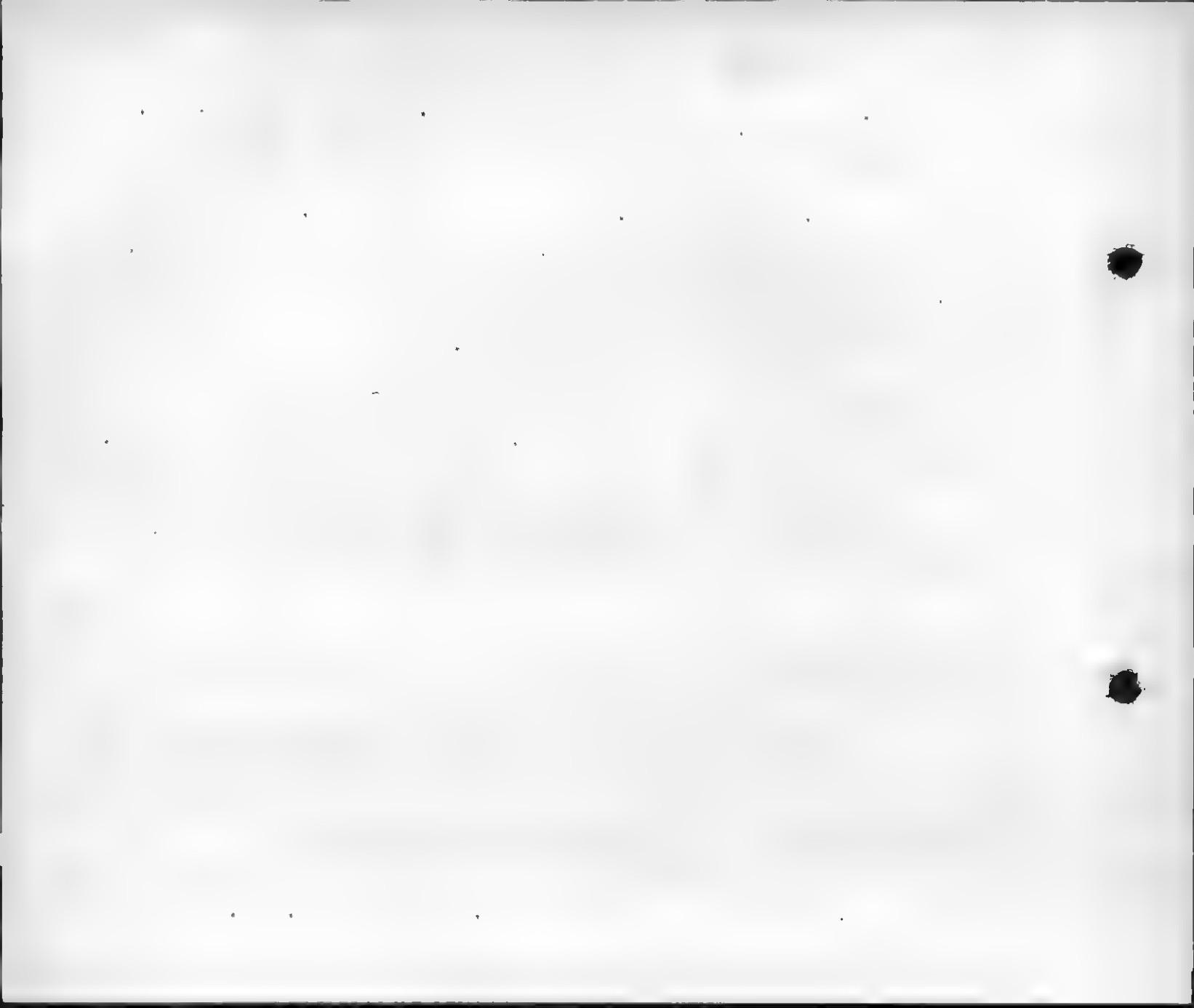
7675

CERTIFICATE OF DEATH

Reg. Dist. No.

07660

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 1 year				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home 301 W. Chesapeake Ave.		d. STREET ADDRESS 533 Anneslie Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELIZABETH		First	Middle	lost HAEGERICH	4. DATE OF DEATH July 8, 1958	Month July	Day 8	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1866	9. AGE (In years lost birthday) 92 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker (rtd)		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Henry Walters		14. MOTHER'S MAIDEN NAME Margaret -						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Estella H. Erck - 533 Anneslie Rd.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 4 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)	DUE TO (c)	Arteriosclerosis		5 years.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 100. (City or town) (County) (State)				
21. I certify that I attended the deceased from alive on 5 July 1958 , and that death occurred at 9A M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE Charles H. Reier				620 17th St		Baltimore 12 Md.		
PHYSICIAN'S NAME (Type) Charles H. Reier								
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.		22d. LOCATION (City, town, or county) Balto., Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fischer & Sons - Balt., Md.		ADDRESS 17th St		24a. REC'D. BY REGISTRAR JUL 14 '58		24b. REGISTRAR'S SIGNATURE Reeser		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7676 Item #2 17/11/58
CERTIFICATE OF DEATH

Reg. Dist. No. 07661

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 5lyr 5mth 21dys		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Pasadena		
f. STREET ADDRESS Springfield State Hospital			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Franklin	Last Haines	4. DATE OF DEATH July 11 1958	Month Day Year
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1880	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Thomas S. Haines			14. MOTHER'S MAIDEN NAME Annie Carter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address	
no					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 15 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 24, 1958, to July 11, 1958, that I last saw the deceased alive on July 11, 1958, and that death occurred at 5:30a.m. from the causes and on the date stated above ACTUAL SIGNATURE Stella Wachsler M.D. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-11-58					
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/58		22c. NAME OF CEMETERY OR CREMATORIAL Gormane Park	
22d. LOCATION (City, town, or county) Baltimore Co Md.		(State)			
24a. REC'D BY REGISTRAR MacEachron		DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE MacEachron	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on a burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7677

CERTIFICATE OF DEATH

07662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1518 ROSEWICK AVE		d. STREET ADDRESS 1518 ROSEWICK AVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HELEN C. HAMILTON	First	Middle	A. Lost
4. DATE OF DEATH 7/23/1958	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1878
9. AGE (In years/last birthday) 80 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE MD	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WM. H. SCHWARTZ		14. MOTHER'S MAIDEN NAME JULIA C. BANDELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT FLORENCE KAHLER 1518 ROSEWICK AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		19. INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0			
(b) DUE TO Arteriosclerotic heart disease		5 years.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1954 to July 1955 , that I last saw the deceased alive on June 1958 , and that death occurred at 4 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George D. Edwards		ADDRESS (Street, city or town, state) 9660 Belair Rd. Balto (6) Md.	
PHYSICIAN'S NAME (Type) George D. Edwards, M. D.		DATE SIGNED 7/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/26/58	
22c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE		22d. LOCATION (City, town, or county) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Laurene F. Thompson 3218 Hudson St		24a. REC'D BY REGISTRAR DATE III 28 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE DeL. C. Hill	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07663

FOR STATE
HEALTH-DERT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 1g. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

o COUNTY

Balto Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catoonsville

c. LENGTH OF STAY IN lb

1 yr.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

646 Ingleside Ave.

3. NAME OF
DECEASED
(Type or print)

First FRED

Middle HARPER

Last

4. DATE
OF
DEATH

July 26

Month

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or former)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Gun shot in head

Conditions, if any, which

gave rise to immediate cause

(a), storing the underlyingcause last.

(b)

DUE TO

#22 Caliber revolver

(c)

DUE TO

Suicide

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY

PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Shot himself in right side of head

20c. TIME OF INJURY Month, Day, Year

Hour

10-1 AM 7-26-58

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

temple region. Self inflicted

20f. (County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Geo. S. Kieffer M.D.

22a. BURIAL, CREMATION

REMOVAL (Specify)

Burial

7/29/58

22b. DATE THEREOF

Greenmount

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

Carroll Co. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

28

24a. REC'D BY REGISTRAR

DATE JUL 31 '58

24b. REGISTRAR'S SIGNATURE

Abdullah

DATE

Abdullah

Signature

Abdullah



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

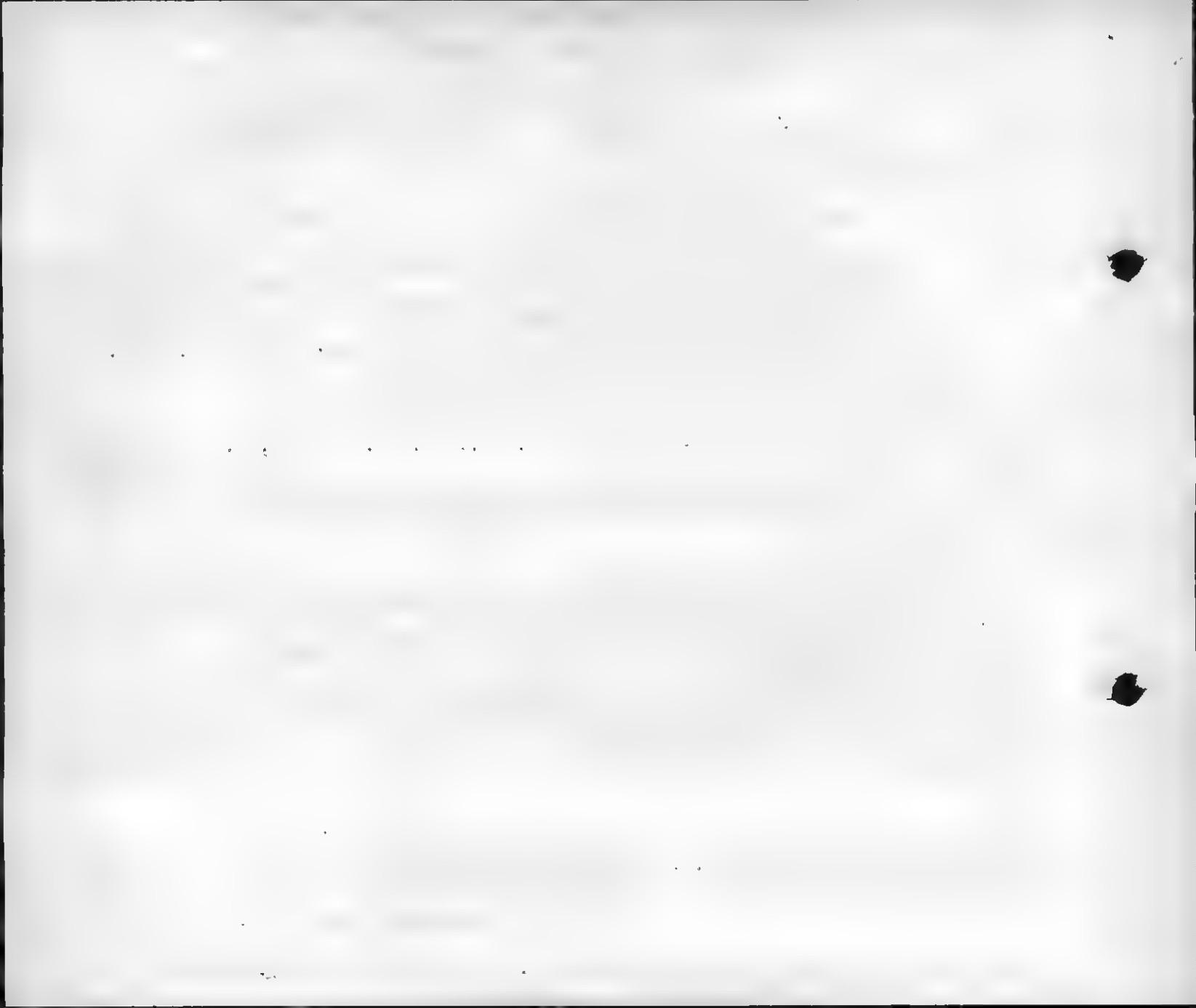
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7679

CERTIFICATE OF DEATH

Reg. Dist. No 7664

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 65 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d STREET ADDRESS 729 East 22nd Street	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle E.	Last HARRIS	4. DATE OF DEATH Month July	Month Day	Year 13	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1899	9. AGE (In years 1st birthday) 59	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS Days 0	12. Months Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Tom Harris		14. MOTHER'S MAIDEN NAME Josephine Garrison					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO 215-05-8219	17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EMPHYSEMA AND CHRONIC BRONCHITIS - Duration Unknown 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. VAH, FORT HOWARD, MARYLAND	(County) 7/14/58	(State) MD	
21. I certify that I attended the deceased from May 9, 1958, to July 13, 1958, and that death occurred at 8:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE J. Freeman ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 7/14/58							
22a. BURIAL, CREMATION OR REMOVAL Burial		22b. DATE THEREOF July 18, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson Funeral Home		ADDRESS 1000 Brantley Ave. Baltimore, Md.	24a. REC'D BY REGISTRAR JUL 16 '58	24b. REGISTRAR'S SIGNATURE Aschuck	DATE		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07665**

D

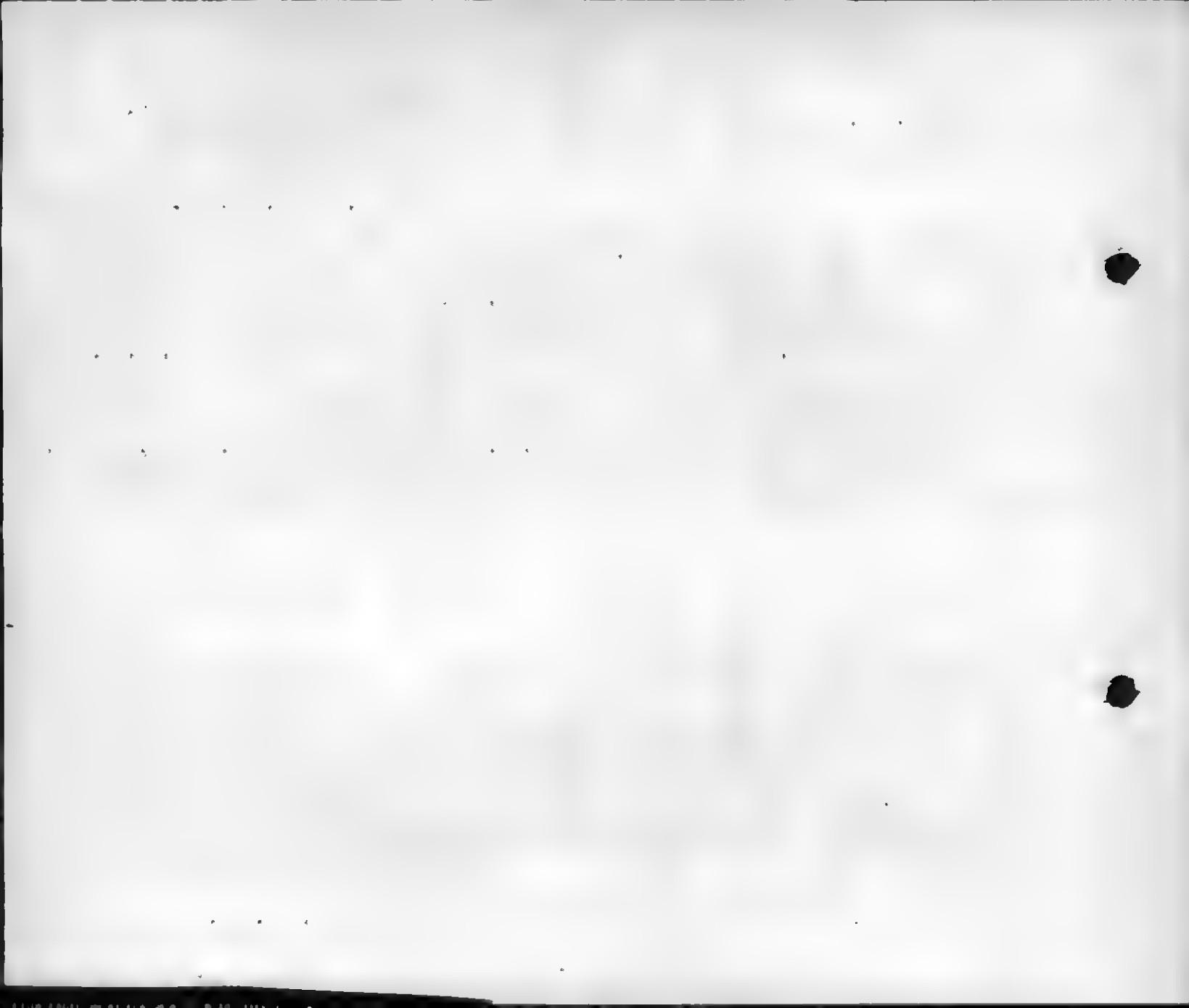
M

I

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certifying date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Balto. Md.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bear Creek		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		d. STREET ADDRESS 929 Lance Ave. Balto. 21, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William		First	Middle R.	Last Hartley	4. DATE OF DEATH Aug. 17, 1922	Month July	Day 5	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1922	9. AGE (in years less than 1 year) 35 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glenn L. Martin Co.			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) West Virginia		
13. FATHER'S NAME Sanford Hartley				14. MOTHER'S MAIDEN NAME Bertha Murray				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-20-4410		17. INFORMANT Mrs. C. Hartley 929 Lance Ave. Balto. 21, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) J. Rowdy G.								
DUE TO 850								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) No								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from boat while starting motor								
20c. TIME OF INJURY Month, Day, Year 3:30 p.m. 7-4 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, store, office bldg., etc.) Bear Creek		20f. (City or town) Baltimore - Md.		(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE M. B. Davis								
EXAMINER'S NAME (Type) M. B. Davis MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Bel-Air Memorial		22d. LOCATION (City, town, or county) Balto. Co. Md.		
(State) MD								
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connally								
ADDRESS 118 Eastern Blvd. Balto. 21								
24a. REC'D. BY REGISTRAR JUL 9 '58								
24b. REGISTRAR'S SIGNATURE J. G. Connally								

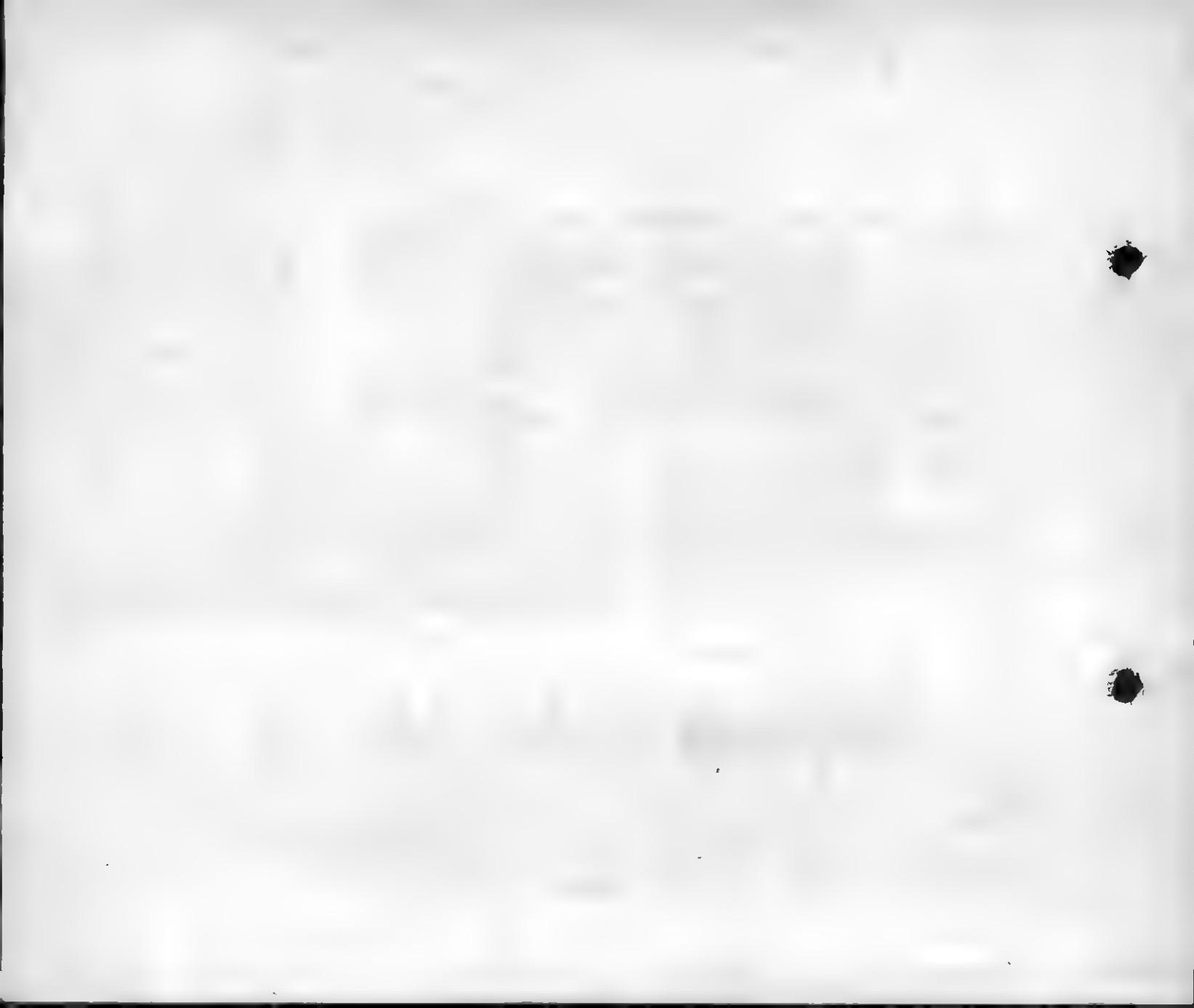


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATIME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07666	
										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Baltimore</i>					c. LENGTH OF STAY IN lb <i>Life</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7722 Wilson Avenue</i>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville - rural - Baltimore</i>						
3. NAME OF DECEASED (Type or print) <i>John Bowman</i>					First <i>J</i>	Middle <i>H</i>	Last <i>Heckner</i>	4. DATE OF DEATH Month <i>July</i>	Day <i>24</i>	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1903-03-03</i>	9. AGE (in years last birthday) <i>54 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Milkman</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>John Heckner</i>					14. MOTHER'S MAIDEN NAME <i>Ella V Iceland</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>215-10-2605</i>	17. INFORMANT <i>Ellen M. Heckner same.</i>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Myocardial Deterioration</i>					INTERVAL BETWEEN ONSET AND DEATH <i>undet.</i>						
DUE TO <i>+D.I.</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>											
DUE TO <i>(c)</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>	(County) <i>md</i>	(State) <i>MD</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John C. Hyde</i>					DATE SIGNED <i>7-24-58</i>						
EXAMINER'S NAME (Type) <i>John C. Hyde</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 28, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. John's Luth. cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore Co. md</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lazarus Funeral Home</i>					ADDRESS <i>7401 Belair Rd.</i>						
					24a. REC'D BY REGISTRAR DATE JUL 28 '58						
					24b. REGISTRAR'S SIGNATURE <i>Albert Edrich</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7682

CERTIFICATE OF DEATH

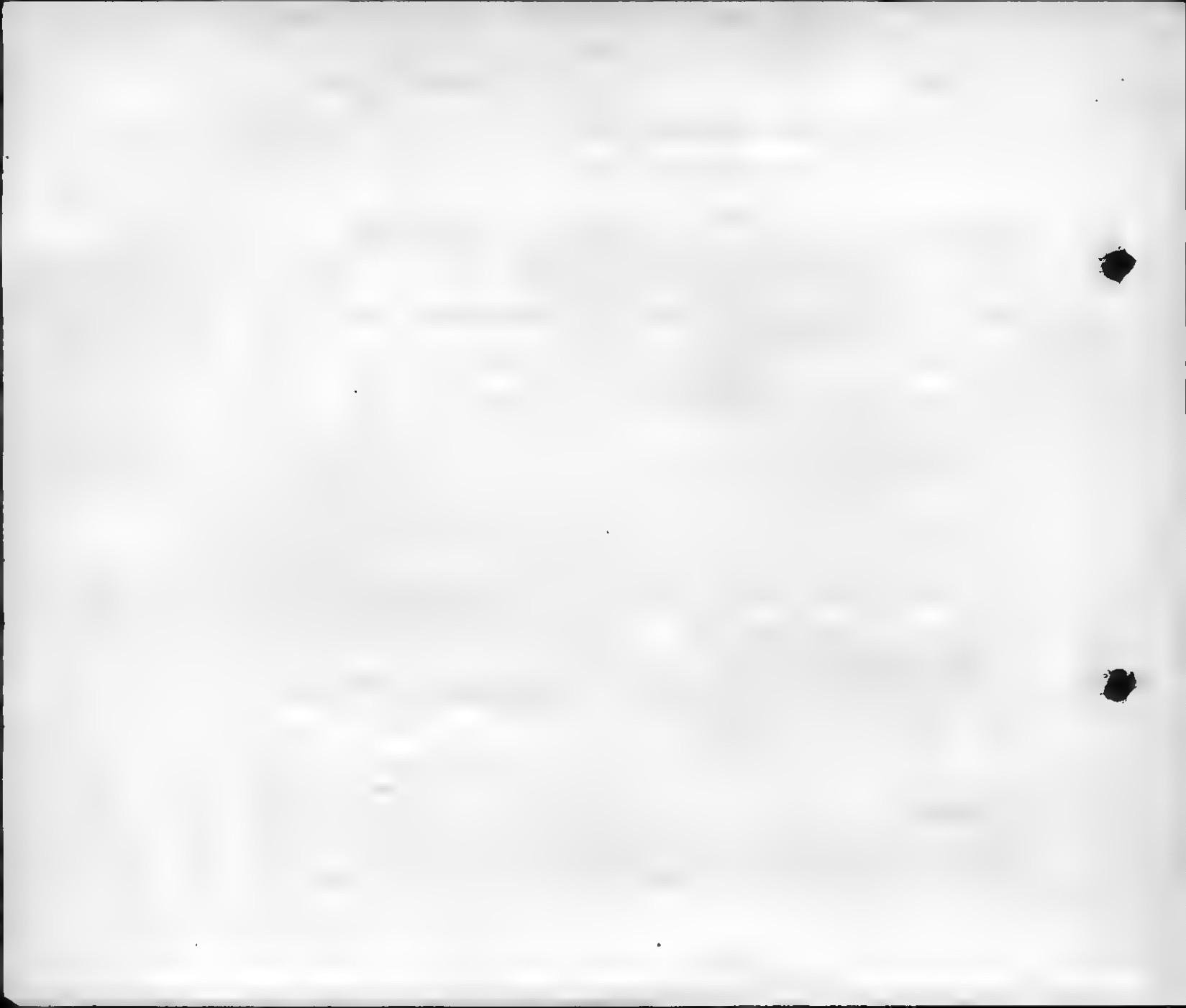
07667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb COCKEYNSVILLE 15 YEARS		d. STATE MARYLAND b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print)		First HOWARD	Middle LEE	Last HENNEMAN	4. DATE OF DEATH JULY 30 1958
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME JOHN H HENNEMAN		14. MOTHER'S MAIDEN NAME ELLA HARTZELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-6938		17. INFORMANT Frank L. Smith Jr. - Cockeysville Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterios Deformatio Cardis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 4-30, 1947, to _____ 7-29, 1958, that I last saw the deceased alive on _____ 7-29, 1958, and that death occurred at 12:30 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) COCKEYSVILLE, MD	
ACTUAL SIGNATURE Halter, Jr. Kies		M.D.		DATE SIGNED 7/30/58	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-2-58		22c. NAME OF CEMETERY OR CREMATORIUM Loulon Park Cemetery	
22d. LOCATION (City, town, or county) Baltimore				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 117 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR JUL 31 '58	24b. REGISTRAR'S SIGNATURE DeLoach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7683

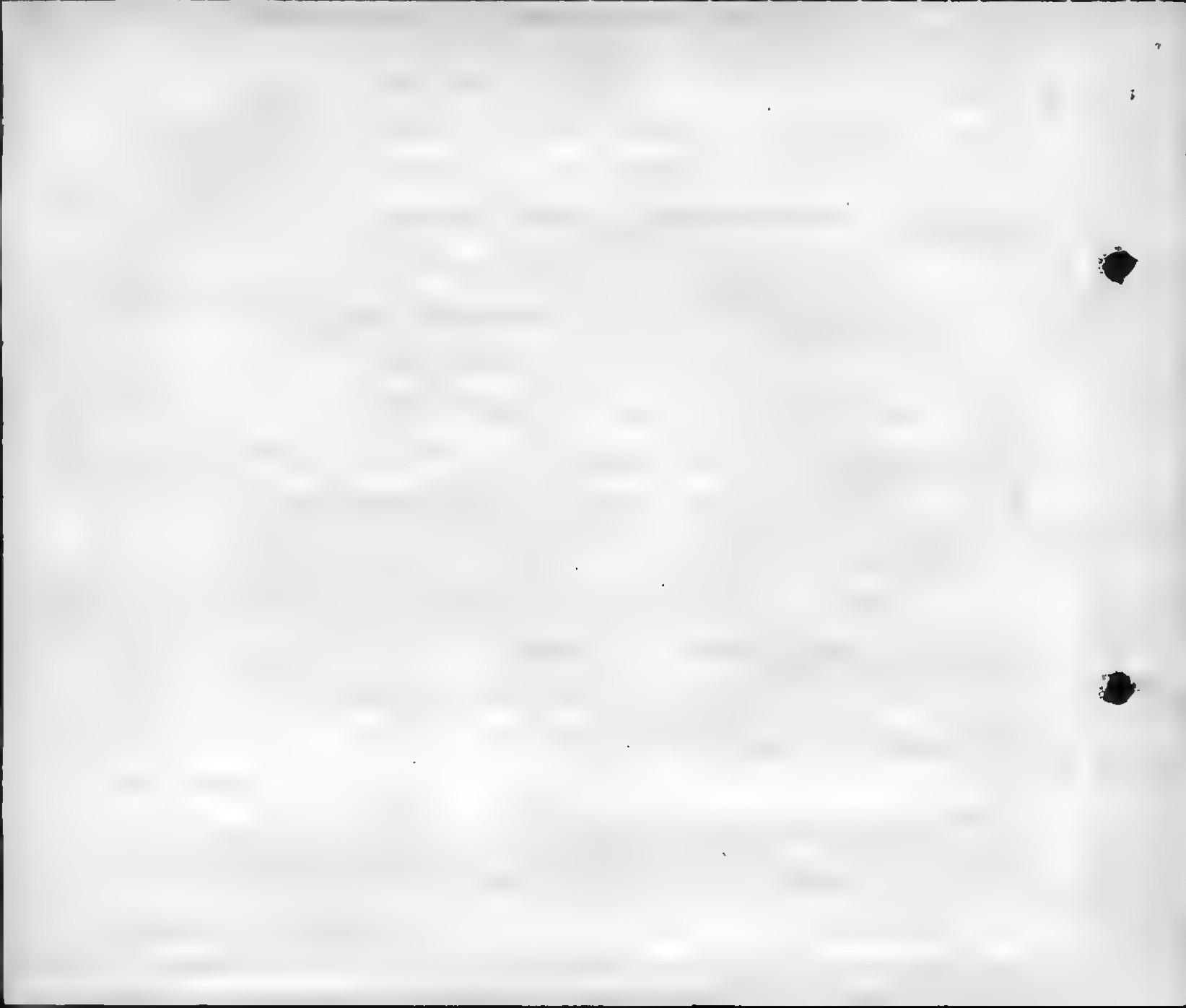
CERTIFICATE OF DEATH

07668

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as a burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>6 yrs.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>105 Smithwood</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Charles W. Henry</i>		First	Middle	
		Last	4. DATE OF DEATH <i>7/19/58</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/15/98</i>	
9. AGE (In years (est. b'day)) <i>60 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C. H. Learco</i>	11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		13. FATHER'S NAME <i>Charles W. Henry</i>		
14. MOTHER'S MAIDEN NAME <i>Caroline Schmitz</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO <i>W</i>		17. INFORMANT <i>Mary Waldvogel</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative C. V. Disease</i> DUE TO <i>Mother Cardiac hypertrophy</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO <i>Cardiac Decomp. made w/ coronary occlusion terminal</i> Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Loudon Park</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>13 June 1958</i> to <i>19 July 1958</i> , that I last saw the deceased alive on <i>19 July 1958</i> , and that death occurred at <i>7:30 AM</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joseph E. Muse Jr. M.D.</i>				
PHYSICIAN'S NAME (Type) <i>JOSEPH E. MUSE JR M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/23/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park</i>	22d. LOCATION (City, town, or county) <i>Balto. Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>MacNaught & Son</i>		ADDRESS <i>28</i>	24a. REC'D BY REGISTRAR DATE JUL 23 '58	24b. REGISTRAR'S SIGNATURE <i>A. L. French</i>

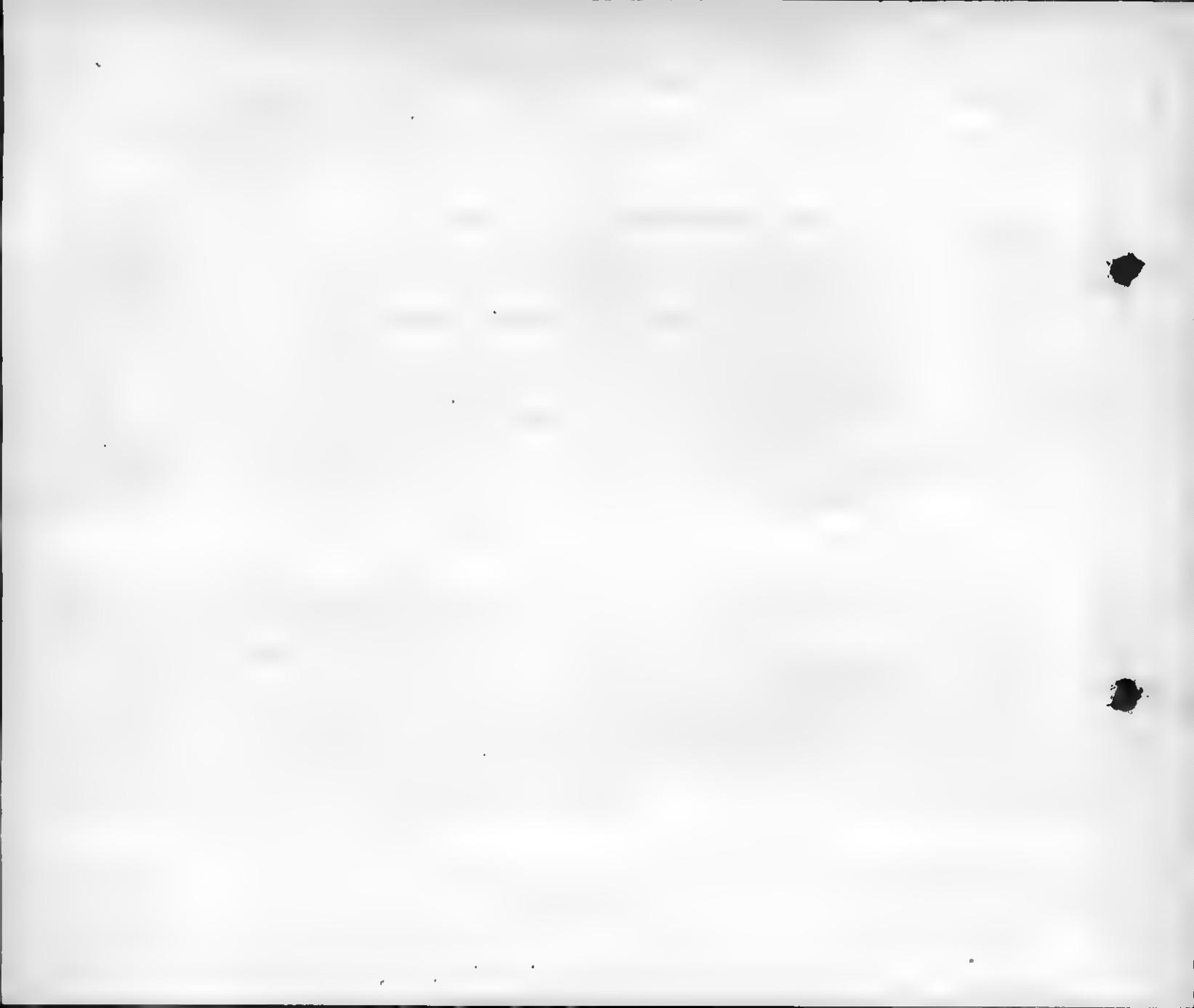


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7684 Items 10a 11 12 14 15 21 7-16-58 et
CERTIFICATE OF DEATH

07669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3412 Mayfair Road		d. STREET ADDRESS 3412 Mayfair Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN		First	Middle	Last	4. DATE OF DEATH ROBERT HERBOLD	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1883	9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Charles Herbold		14. MOTHER'S MAIDEN NAME Mary Dietz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Hilda Regina Herbold-3412 Mayfair Rd.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Barcaroma of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Diabetes Mellitus (b) DUE TO (c) Arterio - Sclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4108 Liberty Hts Baltimore 3-11		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 25 - 1958 , to July 5 - 1958 , that I last saw the deceased alive on July 2 - 1958 , and that death occurred at 8:47 AM from the causes and on the date stated above ACTUAL SIGNATURE Earl L. Chambers PHYSICIAN'S NAME (Type) Earl L. Chambers				ADDRESS (Street, city or town, state) 4108 Liberty Hts Baltimore 3-11		DATE SIGNED 7-4-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/1958		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS Ellsworth Armacost-4600 Liberty Hghts Ave.		24a. REC'D BY REGISTRAR JUL 8 '58		24b. REGISTRAR'S SIGNATURE Alfred J. Smith		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7685

CERTIFICATE OF DEATH

07670

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be kept with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>BALTO.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>M.D.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TUCSON</i>	c. LENGTH OF STAY IN lb <i>50 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TUCSON</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>311 LENNOX AVE.</i>		d. STREET ADDRESS <i>311 LENNOX AVE.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) <i>Goldsus</i>	First <i>M.</i>	Middle <i>HINTON</i>	Last <i>7 21 1958</i>	
4. DATE OF DEATH <i>MAR 4, 1875</i>	Month <i>83 yrs.</i>	Day <i>7</i>	Year <i>1958</i>	
5. SEX <i>M</i>	6 COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 4, 1875</i>	
9. AGE (In years last birthday) <i>83 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>HOSPITAL</i>	11 BIRTHPLACE (State or foreign country) <i>N.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>John Hinton</i>	14. MOTHER'S MAIDEN NAME <i>MARIA P</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>160-17-1234</i>	17. INFORMANT <i>MARTHA HINTON - 311 LENNOX AVE</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour.</i>		
DUE TO <i>hypertension</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>atherosclerotic cardiovascular disease</i>		DUE TO <i>20 - 30 years?</i>		
(b)				
DUE TO <i>generalized arteriosclerosis</i>				
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i>July</i>	Day <i>17</i>	Year <i>1958</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 1707 North Orange Ave.</i>	20f. (City or town) <i>Baltimore, Md.</i>	(County)	(State)
21. I certify that I attended the deceased from <i>July 17, 1958</i> to <i>July 18, 1958</i> that I last saw the deceased alive on <i>July 17, 1958</i> , and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above				
ACTUAL SIGNATURE <i>James R. Powder</i>				ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>
PHYSICIAN'S NAME (Type) <i>James R. Powder</i>				DATE SIGNED <i>7-22-58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/25/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Pleasant Rest</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Schatzman Jr. - 1701 McCulloch St</i>		ADDRESS <i>Baltimore, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 25 1958</i>	24b. REGISTRAR'S SIGNATURE <i>John Smith</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7686

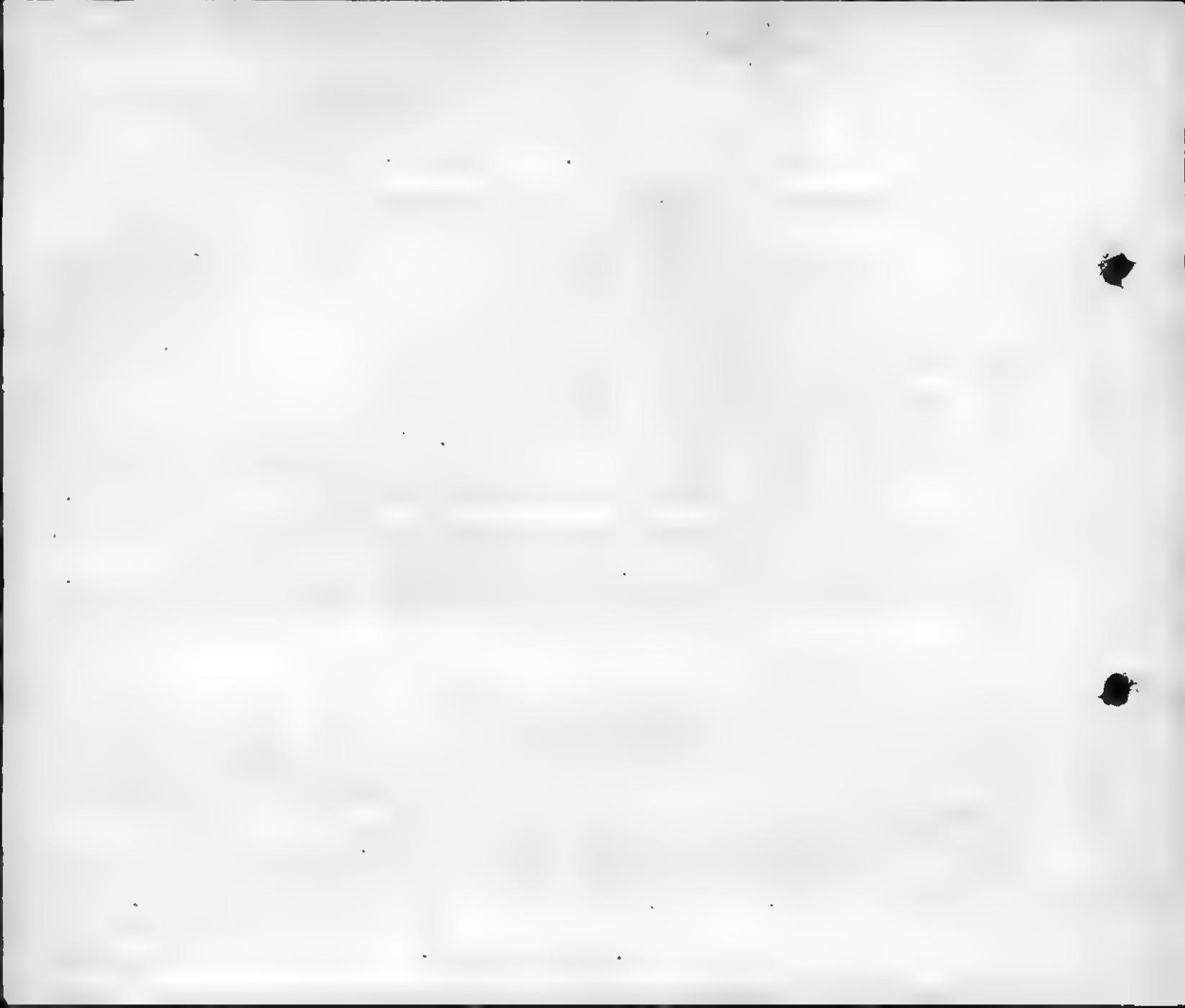
CERTIFICATE OF DEATH

07671

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 Page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix, (rural)		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jarrettsville Pike		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix, (rural)	
3. NAME OF DECEASED (Type or print) Julia Howard		First Julia	Middle Howard
4. SEX female	5. COLOR OR RACE white	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH 7-28-1880
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9. AGE (In years lost birthday) 77 yrs	
10a. KIND OF BUSINESS OR INDUSTRY home		10b. PLACE (State or foreign country) Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Howard		14. MOTHER'S MAIDEN NAME Mary Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Grace M. Lins		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO Hypertensive Arteriosclerotic C.V.D. (c) DUE TO Congestive heart failure			
INTERVAL BETWEEN ONSET AND DEATH 9 mos.			
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a) marked Dehydration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Sept. 1957 , to 10 July 1958 , that I last saw the deceased alive on 10 July 1958 , and that death occurred at 11:55 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Abraham, M.D.</i>		ADDRESS (Street, city or town, state) Robert A. Abraham, M.D.	
PHYSICIAN'S NAME (Type) <i>Robert A. Abraham, M.D.</i>		DATE/SIGNED 10/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-58	
22c. NAME OF CEMETERY OR CREMATORIUM Ashland Presbyterian		22d. LOCATION (City, town, or county) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Scott Brooks</i>		ADDRESS 622 York Rd., Towson 4, Md.	
		24a. REC'D BY REGISTRAR JUL 15 '58	
		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7687

CERTIFICATE OF DEATH

Reg. Dist. 07672

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE BALTIMORE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	c. LENGTH OF STAY IN 1b 6 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	d. STREET ADDRESS 3913 ST VICTOR STREET
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NAYNE NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMETT	First HOLLAND	Middle JULY	Month 18
4. DATE OF DEATH MARCH 31 1867	Day 18	Year 1958	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 91
9. AGE (In years lost birthday) 91	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	10b. KIND OF BUSINESS OR INDUSTRY SHIP BUILDING	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME UNK.		
14. MOTHER'S MAIDEN NAME MARY PRINGLE	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) NO		
16. SOCIAL SECURITY NO	17. INFORMANT STANLEY P. HOLLAND SAME	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) L.C.U.O DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 52	20f. (City or town) 7/18/58
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, and that death occurred at 4:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1303 Frederick Rd	DATE SIGNED 7/18/58
ACTUAL SIGNATURE John McGrath	M.D.	PHYSICIAN'S NAME (Type) John McGrath	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/12/58	22c. NAME OF CEMETERY OR CREMATORIUM GLEN HAVEN PARK	22d. LOCATION (City, town, or county) GLEN BURNIE A Co, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Jones	ADDRESS 4001 Gov. RITCHIE Hwy	24a. REC'D BY REGISTRAR DATE JUL 23 '58	24b. REGISTRAR'S SIGNATURE John Smith



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7688 CERTIFICATE OF DEATH

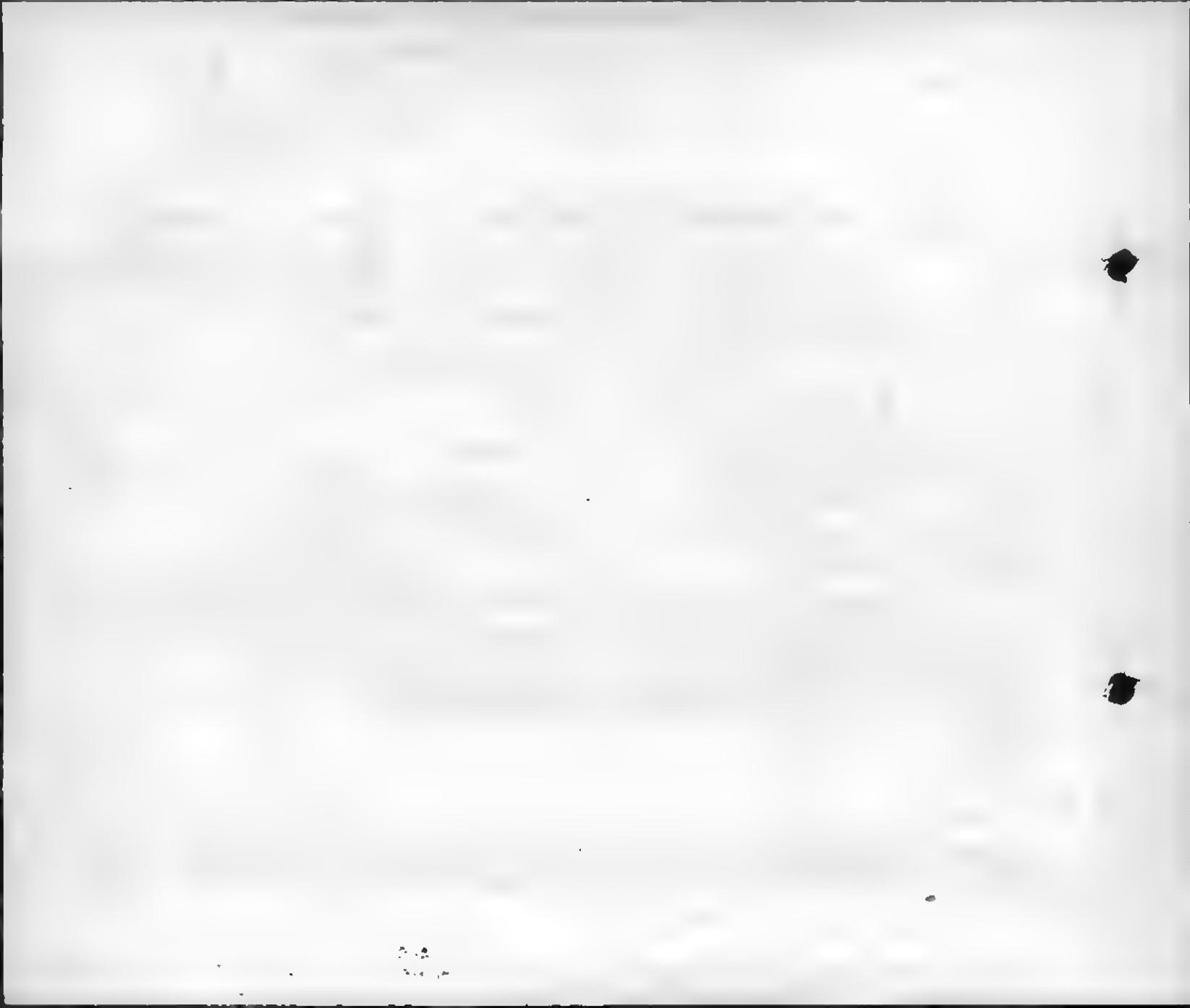
07673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Baltimore</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 1 year	
<i>CATONSVILLE</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>726 MARTIN Drive</i>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Ida</i>			<i>Hodde</i>
4. DATE OF DEATH	Month	Day	Year
	<i>JULY</i>	<i>31</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>FEMALE</i>	<i>WHITE</i>		<i>OCT. 12-1874</i>
9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
<i>83 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>TAILOR</i>		<i>Clothing Mfg.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Baltimore</i>		<i>U. S. A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Julius Hodde</i>		<i>KUNNIGUNDA JONES</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>NO</i>		<i>213-10-7742</i>	
17. INFORMANT		Address	
<i>MRS. LILLIAN E. NAFF</i>		<i>726 MARTIN DRIVE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Acute G.I.-tract bleeding, site and cause undetermined</i>		<i>48 Hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Generalized Arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-28-58</i> , 19, to <i>7-31-58</i> , 19, that I last saw the deceased alive on <i>7-30-58</i> , 19, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Nathan Racusin</i> ADDRESS <i>206 S. Gilmore St</i> DATE SIGNED <i>7-31-58</i>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <i>NATHAN RACUSIN</i>		22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>Aug 4, 1958</i> 22c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i> 22d. LOCATION (City, town, or county) <i>Balto. Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Truman Schub</i>		24a. REC'D BY REGISTRAR DATE AUG 4 '58 24b. REGISTRAR'S SIGNATURE <i>Alv. Schub</i>	
ADDRESS <i>3512 Frederick Ave. Balt. (29)</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 1 hour after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

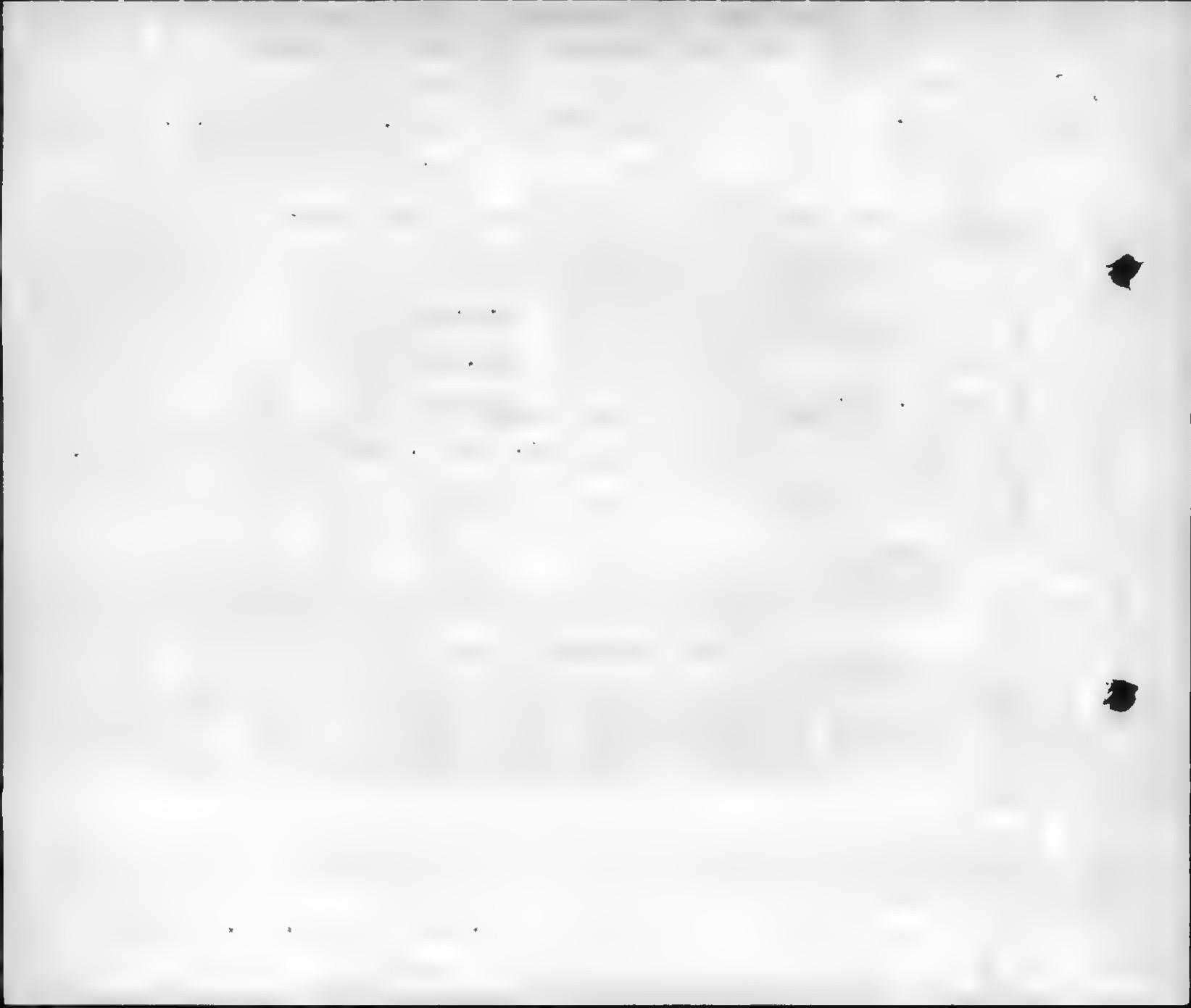
VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7689 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		b. COUNTY A. A.	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearwater Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines		d. STREET ADDRESS 8227 Parkway Drive.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VIRGINIA	Middle BELL	Last HONEYWELL
4. DATE OF DEATH	Month July	Day 3	Year 19 58
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1865
9. AGE (in years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
10c. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph B. Mitchell		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Elmer M. Honeywell - 8227 Parkway Dr.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <i>Acute myocardial failure</i> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Branch of incisor</i> 903.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> <i>Cardiovascular disease</i> DUE TO <i>Fractional femur accident</i> DUE TO <i>Fracture femur accident</i> INTERVAL BETWEEN ONSET AND DEATH <i>Die fell in plaster cast May 18, 58</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Die fell in plaster cast May 18, 58</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on floor going to bath Room</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. May 18 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Room	20f. (City or town) Baldo Md (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE: <i>Gen M Kieffer</i>	DATE SIGNED <i>July 3, 58</i>		
EXAMINER'S NAME (Type) GEZ. S. M. KILFFER MD	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/58	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	22d. LOCATION (City, town, or county) Balto. Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Dickner & Sons</i>	ADDRESS Baltimore 17 Md.	24a. REC'D BY REGISTRAR Jul 7 '58	24b. REGISTRAR'S SIGNATURE <i>John J. Dickner</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07675

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH

a. COUNTY
Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore Chase

c. LENGTH OF STAY IN 1b

8 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Box 124 Chase Md.

3. NAME OF
DECEASED
(Type or print)

First Middle
Stuart Lee Huffman

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

DIVORCED

2 USUAL RESIDENCE (Where deceased lived. If institution or residence before admission)

a. STATE
Maryland

b. COUNTY
Balto.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Baltimore

d. STREET ADDRESS

Box 124 Chase Md.

e. IS RESIDENT
ON A FARM?
YES NO

Lost

4. DATE
OF
DEATH

July

Month

Doy Year
27 19 58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Assemblyman

13. FATHER'S NAME

Stuart L. Huffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or date of service)

Yes WW 2

16. SOCIAL SECURITY NO.

213-24-6358

17. INFORMANT

Mrs. Alice T. Huffman

Address

Box 124 Chase Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-20.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

INTERVAL BETW. EN
ONSET AND DEATH
4.5 min.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19

20d. INJURY OCCURRED
White Not white
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial 7-31-1958

22b. DATE THEREOF

7-31-1958

22c. NAME OF CEMETERY OR CREMATORIUM

Parkwood Cem.

22d. LOCATION (City, town, or county)

(State)

Baltimore

N.D.

23. FUNERAL DIRECTOR'S SIGNATURE

Leeds & Funeral Home 7401 Belair Road #c

ADDRESS

24a. REC'D BY REGISTRAR

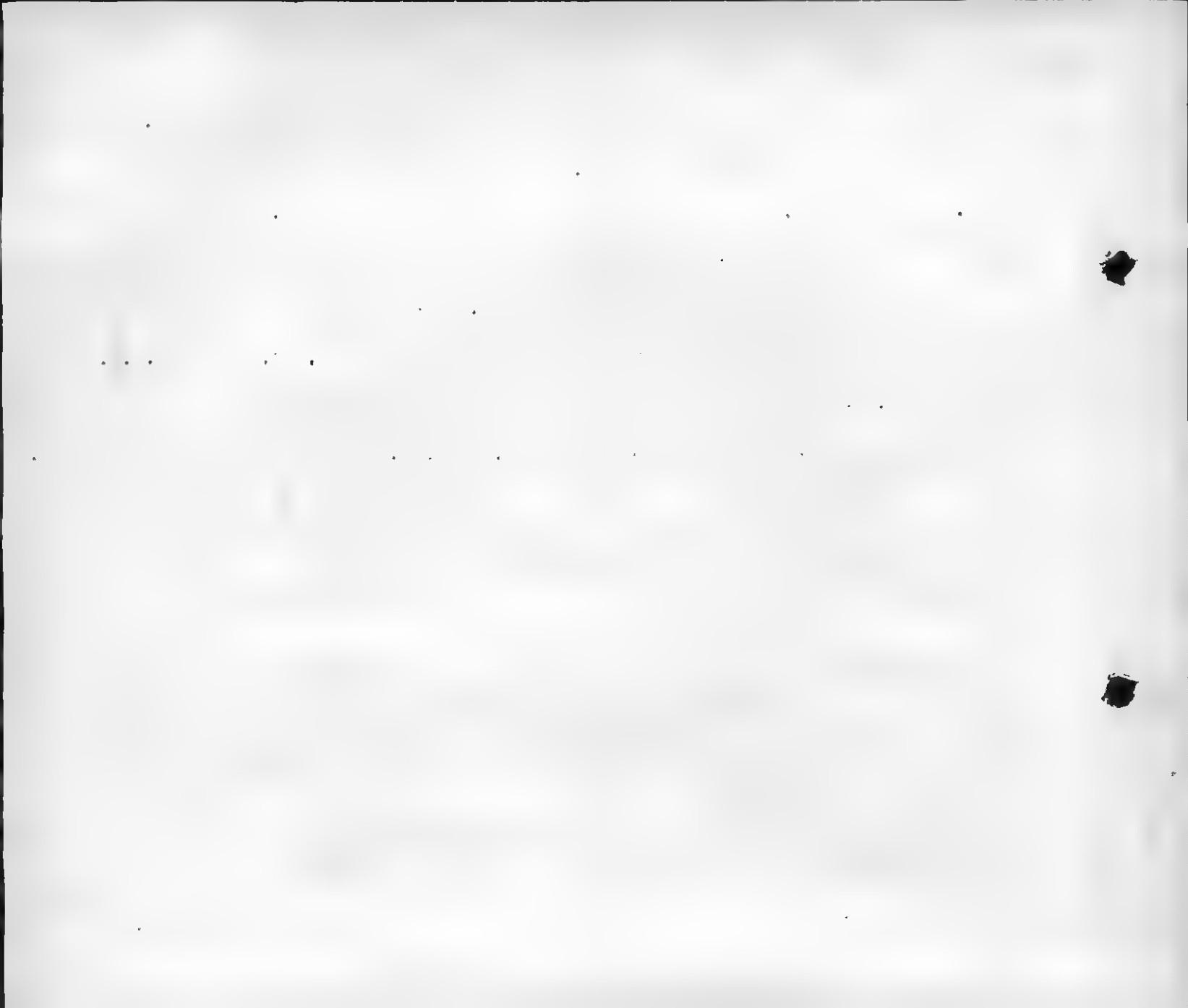
JUL 31 1958

24b. REGISTRAR'S SIGNATURE

W. J. Reich

DATE SIGNED

7-29-58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7691

CERTIFICATE OF DEATH

Reg. Dist. No. 17676

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b RURAL (and give nearest town) VENTNOR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES NURSING HOME		e. STREET ADDRESS 02	
3. NAME OF (Type or print) IDA		First C.	Middle HUMPHREYS
4. DATE OF DEATH JULY 3, 1958	Month 19	Day 19	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 13, 1886
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	10c. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.
13. FATHER'S NAME JOHN F. MESZ		14. MOTHER'S MAIDEN NAME ELIZABETH MUHLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown)		16. SOCIAL SECURITY NO 218 32 0353	17. INFORMANT MR. JOHN MESZ 12 DUTTON AVENUE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) Myocardial Decomposition DUE TO (c) coronary Thrombosis DUE TO (d) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 <input type="checkbox"/> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-21-1958 , to 7-3-1958 , that I last saw the deceased alive on 7-2-1958 , and that death occurred at 6 a.m. M, from the causes and on the date stated above. ACTUAL SIGNATURE Wilmer K. Gallagher M.D. 6209 Frederick Ave. DATE SIGNED 7-3-58		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/58	
22c. NAME OF CEMETERY OR CREMATORIUM WOODLAWN CEMETERY		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE		24a. REC'D BY REGISTRAR DATE JUL 7 '58	24b. REGISTRAR'S SIGNATURE Alv. Sander

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use on the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 17677

7692

I
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
ESS		2415	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
NICHOLAS			IVANCEVIC
3. NAME OF DECEASED (Type or print)		Last	4. DATE OF DEATH
NICHOLAS		JULY 8 -	Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-19-1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Carpenter		Building Const. Yugoslavia	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Miso Ivancevic		12. CITIZEN OF WHAT COUNTRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service) No		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		STEAMCOULATION caused by HANGING	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Knew self from Slov. Room in bathroom	
20c. TIME OF INJURY Month, Day, Year 7-8 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) County) State) Home Essex-21-Bs-Lw-Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	M.B. Davis M.D.		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
Burial	7/11/58	Sacred Heart & Jesus Cemetery	Germantown Hill Rd. Baltw Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
A. Christine Brugman	1407 Eastern Ave	DATE JUL 11 '58	Quesenbach



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7693

CERTIFICATE OF DEATH

07678

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 527 Pontiac Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	(Served as WICZENTY VINCENT	Middle ---	JARASWICZ)	4. DATE OF DEATH July	Month Year	Day 26	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1889	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter -Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME John Jaraswicz				14. MOTHER'S MAIDEN NAME Antonia Mikolisik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW-I		17. INFORMANT Clin.Rec.Vet.Adm.Hospital, Ft. Howard, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMBOLUS DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE				INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 7 DAYS UNKNOWN			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) VAH	(County) (State)
21. I certify that attended the deceased from July 23, 1958, to July 26, 1958, and that death occurred at 11:45 AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Hiram B. Curry, M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) HIRAM B. CURRY, M.D. VA HOSPITAL, FT. HOWARD, MD. DATE SIGNED 7/27/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 31, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)				
23. FUNERAL DIRECTOR'S SIGNATURE George H. RITCHIE, H.A.		ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 31 '58	24b. REGISTRAR'S SIGNATURE A. L. Finch			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use of a carbon-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



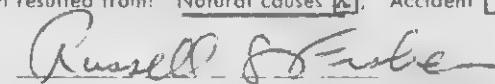
FOR STATE
HEALTH DEPT.

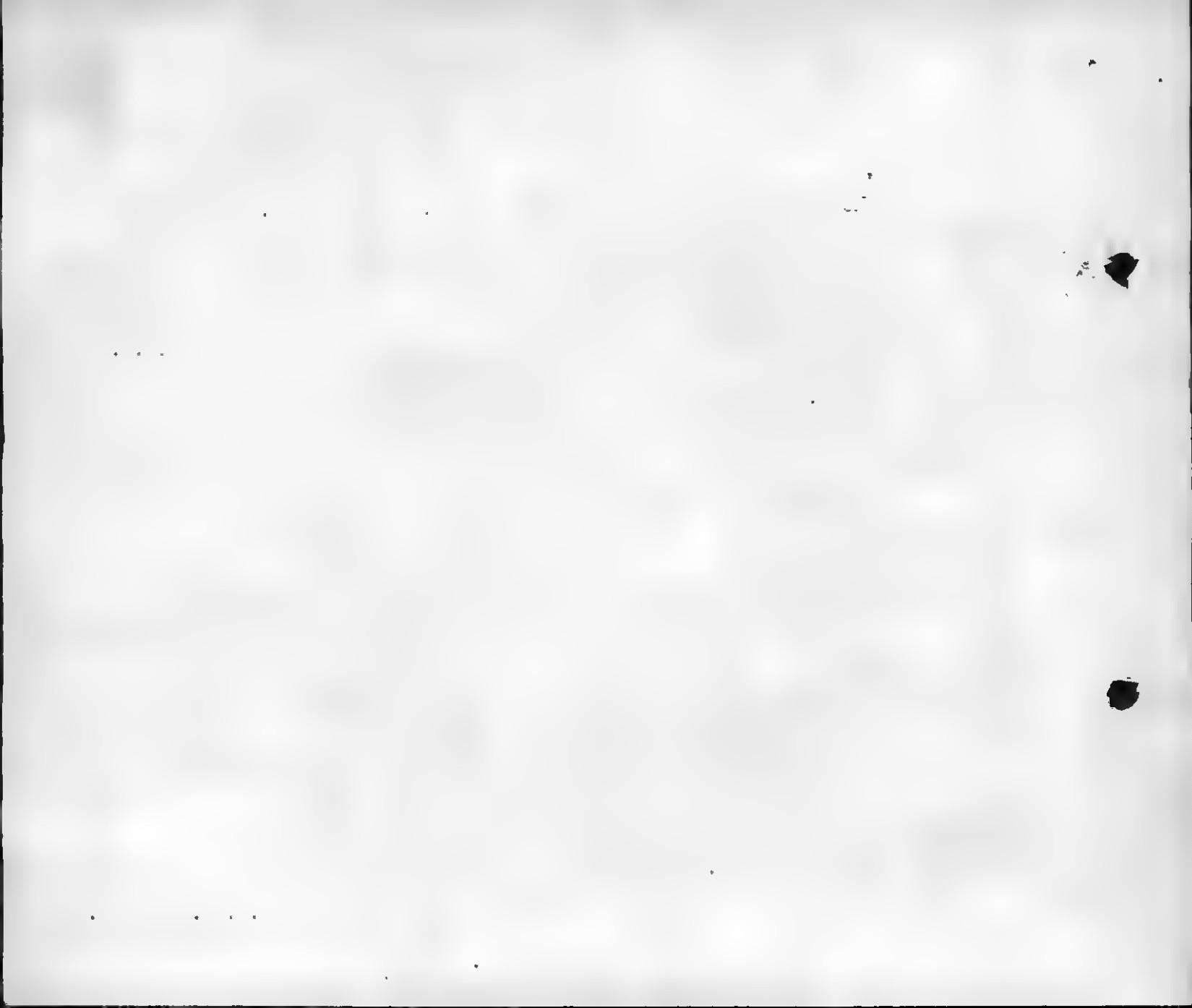
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it "PENDING" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07679

7694		Reg. Dist. No.			
1. PLACE OF DEATH o COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Dispensary		Baltimore			
e. STREET ADDRESS 1234 E. Lafayette Ave.		e. IS RE BORN ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. FIRST MIDDLE LAST WALTER JONES		f. DATE OF DEATH July 7 1958			
g. SEX Male COLOR OR RACE Colored		g. DATE OF BIRTH 9. AGE (in years last birthday) 30 yrs.			
h. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dock Unloader		h. 10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.			
i. 11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
j. 13. FATHER'S NAME Harry E. Jones		14. MOTHER'S MAIDEN NAME Laura Ann Rogers			
k. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> II		l. 16. SOCIAL SECURITY NO Ernest Jones			
m. 17. INFORMANT Same		Address			
n. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stealing the underlying cause lost. DUE TO (c)		o. Acute pneumonitis INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Old left upper lobectomy		p. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
q. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Calvary Cemetery	22d. LOCATION (City, town, or county) Brooklyn, A.A.C.O. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON FUNERAL HOME 1000 Brantley Ave.		ADDRESS	24a. REC'D BY REGISTRAR JUL 16 '58	24b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7695

CERTIFICATE OF DEATH

Reg. Dist. No.

07680

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
<i>Balto Co</i>		MARYLAND <i>md</i>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town)		c. LENGTH OF STAY IN 1b <i>83 yrs</i>	
<i>Catoonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catoonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>120 dmithwood</i>	
<i>120 dmithwood</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Louis J.</i>	Middle <i>Keidel</i>
		Last <i>Louis J. Keidel</i>	4. DATE OF DEATH <i>7/22/58</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/23/74</i>
9. AGE (In years (at birthday) <i>83</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Music teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md.</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Louis Keidel</i>		14. MOTHER'S MAIDEN NAME <i>Emma Braun</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Wm. A. Grimes</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>	
442A Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO <i>Pulmonary embolus.</i>	
{ (b) <i>Thrombophlebitis of leg</i>		DUE TO <i>arterioembolic hypertension due to embolism of leg 5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <i>7-21</i> , 19 <i>58</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>John A. Nissim</i>		M.D. <i>and 28 Paul St</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>7/25/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Gordon Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. McNaughton</i>		ADDRESS <i>28</i>	
		24a. REC'D BY REGISTRAR DATE JUL 28 '58	
		24b. REGISTRAR'S SIGNATURE <i>Weston</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

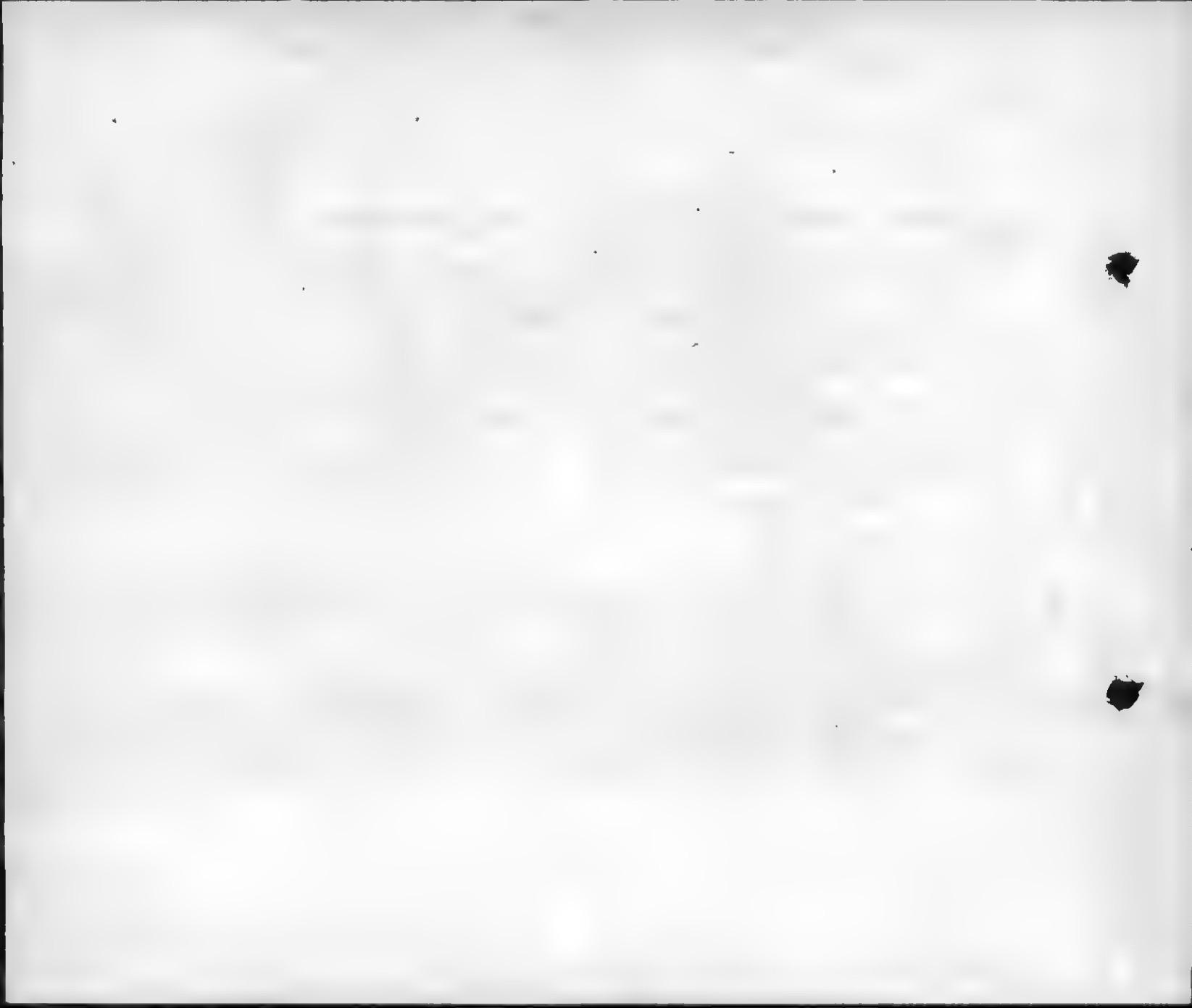
07681

Reg. Dist. No.

7696

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point 19	
c. LENGTH OF STAY IN 1b 34 yrs		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOSPITALITY-BETH. STEEL CO.		e. STREET ADDRESS 908 "D" Street #19	
3. NAME OF DECEASED (Type or print) James		4. DATE OF DEATH 7 - 6 - 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 27, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTOR CAR OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY STEEL WORKER	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S. 17	
13. FATHER'S NAME JAMES A. KELLY, SR.		14. MOTHER'S MAIDEN NAME ANNA WOODLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-0578	
		17. INFORMANT MRS RALPH E. DEARMENT - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car accident	
20c. TIME OF DEATH Month, Day, Year Hour a. m. p. m. 3:17 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAK LAWN
20f. (City or town) BALTO. CO., MD		(County) MD	
		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis	DATE SIGNED 7/6/58		
EXAMINER'S NAME (Type) M.B. Davis MD	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION OR REMOVAL (specify) BURIAL	22b. DATE THEREOF 7/9/58	22c. NAME OF CEMETERY OR CREMATORY OAK LAWN	22d. LOCATION (City, town, or county) BALTO. CO., MD
23. FUNERAL DIRECTOR'S SIGNATURE Wally Brooks Bradley, Leland, MD		ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 8 '58
			24b. REGISTRAR'S SIGNATURE Q.W. Search



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

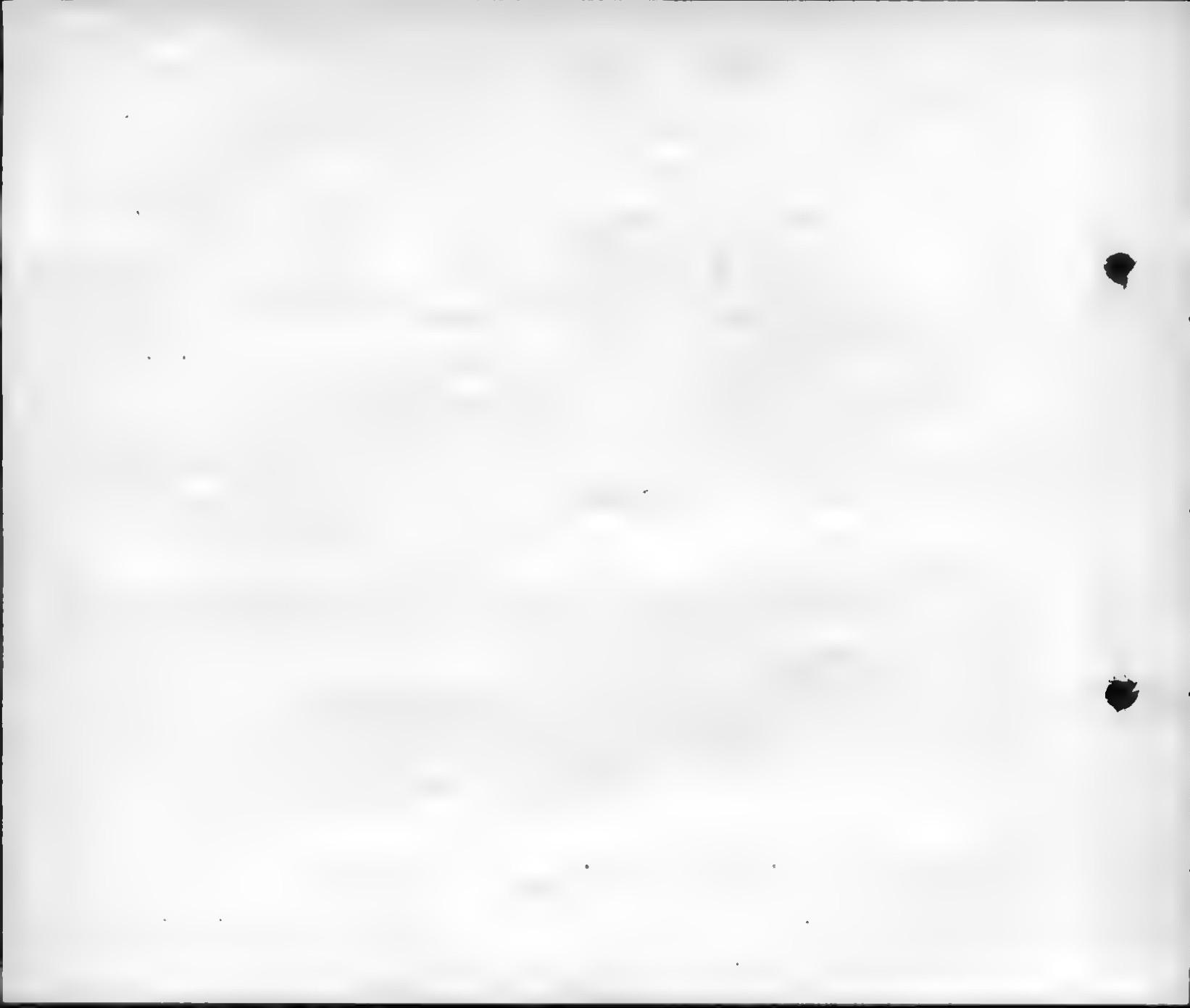
07682

7697

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mthsldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 74 Baltimore	
f. STREET ADDRESS South River Drive - Harewood Pk		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maude Middle Elana Last Kennedy		4. DATE OF DEATH Month July Day 3 Year 19 58	
5. SEX female COLOR OR RACE white		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. B. DATE OF BIRTH July 7, 1881	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) yrs 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Erdman		14. MOTHER'S MAIDEN NAME Molly Schneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27, 1958, to July 3, 1958, that I last saw the deceased alive on July 3, 1958, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE <i>Augusto J. Esquibel</i> 7-3-58			
PHYSICIAN'S NAME (Type) Augusto J. Esquibel, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS. INC. Baltimore		24a. REG'D. BY REGISTRAR JUL 7 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alb. Esquibel</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7898 CERTIFICATE OF DEATH 07683

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 20 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shadynook Nursing Home		d. STREET ADDRESS 625 Linnard St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Agnes	Middle May	Last Klock	4. DATE OF DEATH Month July Day 4/58	Month Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH Feb. 18, 1885	9 AGE (In years last birthday) 73 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME late David M. Funk		14. MOTHER'S MAIDEN NAME Ellie				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address Dr. P.C. MacLaughlin, 303 Rolling Rd. Catons-		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 260X		INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic Cardio-vascular Disease				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Diabetes Mellitus		18 yrs				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chambersburg	(County) Pa.	(State) Pa.
21. I certify that I attended the deceased from Feb. 1958 to July 4, 1958 , that I last saw the deceased alive on July 4, 1958 , and that death occurred at 1:15 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4508 Edmondson Village				
ACTUAL SIGNATURE P. C. MacLaughlin		DATE SIGNED JULY 7 1958				
PHYSICIAN'S NAME (Type) P. C. MacLaughlin						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7/58	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Grove	22d. LOCATION (City, town, or county) Chambersburg, Pa.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, Jr.		ADDRESS 4101 Edmondson Ave	24a. REC'D BY REGISTRAR DATE JUL 7 '58		24b. REGISTRAR'S SIGNATURE Alvarez	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7699

CERTIFICATE OF DEATH

Reg. Dist. No. 07684

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) a. SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
f. STREET ADDRESS 644 Aldworth Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Nellie	Middle Lorraine	Last Kraemer
4. DATE OF DEATH July 1 1958	Month 1	Day 1	Year 19 58
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1898
9. AGE (In years last birthday) yrs 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME James Green		14. MOTHER'S MAIDEN NAME Laura Christ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-16-3240	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost! } (b) DUE TO Generalized arteriosclerosis (c) DUE TO Chronic brain syndrome due to cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH year year year	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Net white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1958, to July 1st, 1958, that I last saw the deceased alive on July 1st, 1958, and that death occurred at 8:45 P.M., from the causes and on the date stated above ACTUAL SIGNATURE Bruno Radauskas, M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 7/1/1958 PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.		24a. REC'D BY REGISTRAR DATE JUL 3 '58	
		24b. REGISTRAR'S SIGNATURE Deutsch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician until the certificate has been signed by the attending physician and completed. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

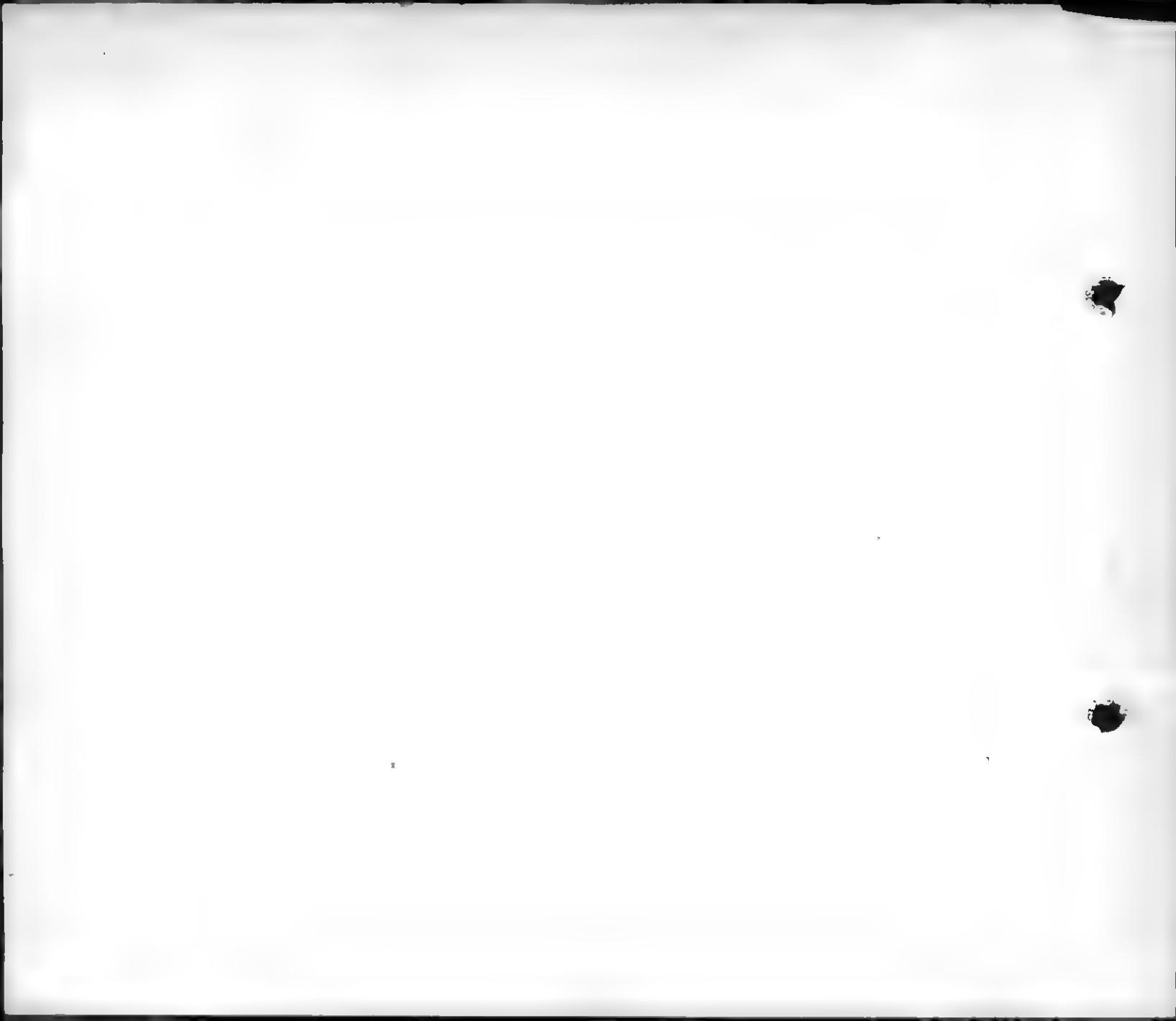
07685

7760

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print)		ALSO KNOWN AS		2 DATE OF DEATH
ROSE Botsky-LACAVITCH-KRAKEVICH				JULY 2, 1958
3. PLACE OF DEATH: A Baltimore City, Maryland Catonsville		4. USUAL RESIDENCE (Where deceased lived, if institution: residence A. STATE MARYLAND B. COUNTY before admission)		
B FULL NAME (If not in hospital institution, give street address or HOSPITAL OR INSTITUTION WAYNE CONValescent Home		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
c. LENGTH OF STAY IN BALTIMORE		Yrs. MOS. Days	D. STREET ADDRESS (If rural, give location) 534 S. Paen St.	
5. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 4-18-1882	9. AGE (In years last birthday) 78 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCERY STORE	10B. KIND OF BUSINESS OR INDUSTRY SELL	11. BIRTHPLACE (State or foreign country) Lithuania	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No	16. SOCIAL SECURITY NO 216-32-2632	17. INFORMANT ADDRESS William Lacs 4109 HARRIS AVE 6.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 ANTECEDENT CAUSES		CAUSE OF DEATH Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 2 months
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO	Hypertensive Cardiovascular Disease, Arteriosclerotic	8 years
II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
22. I hereby certify that I attended the deceased from 6-17, 1950 to 7-2, 1958, that I last saw the deceased alive on 6-25, 1958, and that death occurred at 5:30 P.m., from the causes and on the date stated above.		23A. SIGNATURE John P. Ulrich, Jr.		23B. ADDRESS 1227 Wash Blvd
23C. DATE SIGNED 7-2-58		24A. BURIAL, CREMA- TION, REMOVAL (Specify) Burial		24B. DATE JULY 5, 1958
24C. NAME OF CEMETERY OR CREMATORIAL Most Holy Rosary Cemetery Bel Air Rd		24D. LOCATION (City, town, or county) Maryland		(State)
DATE RECEIVED BY LOCAL REGISTRAR 7-5-58		REGISTRAR'S SIGNATURE D. E. Ulrich		25. FUNERAL DIRECTOR Charles J. Schauskas 631 Wash Blvd



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07686

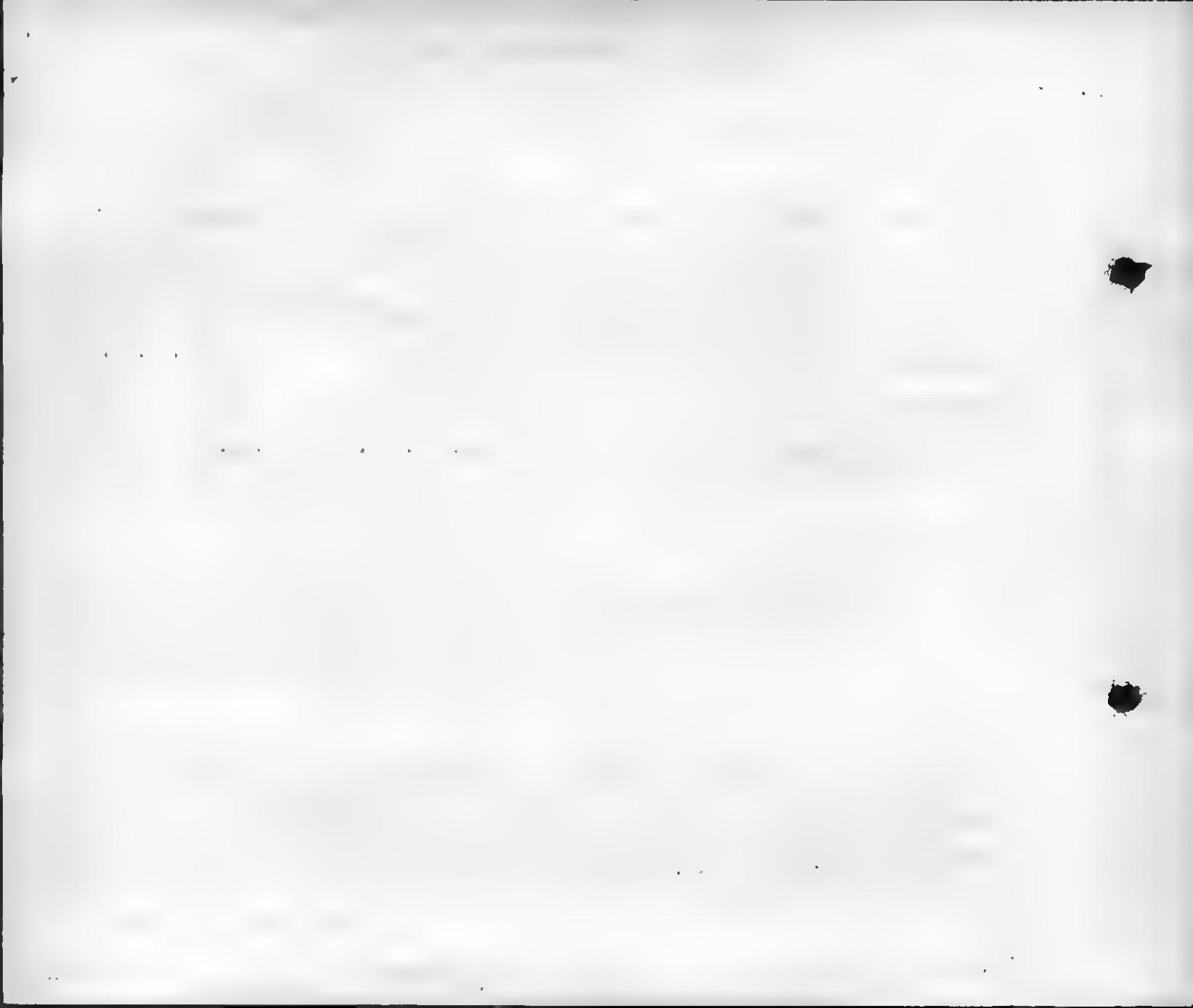
7701 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 21 Days				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 101 Old Annapolis Boulevard				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle J.	Last LACE	4. DATE OF DEATH Month July	Day 15	Year 1958				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH January 1, 1897		9. AGE (in years lost birthday) 61 yrs	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter -unemployed		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME John Lace				14. MOTHER'S MAIDEN NAME Frances Zakouak							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] Yes		16. SOCIAL SECURITY NO. Peace Time Unknown		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO CIRRHOSIS OF LIVER, PORTAL Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.		Month VA	Doy 19	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County) VAH, FORT HOWARD, MARYLAND	(State) MD
21. I certify that I attended the deceased from June 24, 1958 , to July 15, 1958 . and that death occurred at 9:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 7/25/58											
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) MD			
23 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		ADDRESS 6009 Harford Road		24a. REC'D BY REGISTRAR 1650		24b. REGISTRAR'S SIGNATURE <i>John Cook</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

107687

7732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Route #16, Box 264		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BACTOR	Middle R.	Last LANGLEY	4. DATE OF DEATH Month July	Month Day	Day 25	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1886	9. AGE (in years lost birthday) 71	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) Atlanta, Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Langley		14. MOTHER'S MAIDEN NAME Mary J. Whitmire					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WWI 213-07-2616		17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LUNG ABSCESS, RIGHT UPPER LOBE DUE TO 493X						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO PNEUMONIA RIGHT UPPER LOBE						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE - Duration unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1958 to July 25, 1958 , and that death occurred at 2:20 PM , from the causes and on the date stated above and that death occurred at 2:20 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state)						DATE SIGNED 7-26-58	
ACTUAL SIGNATURE <i>Irving Freeman</i>		M.D. Irving Freeman		M.D. Fort Howard, Maryland			
PHYSICIAN'S NAME (Type) IRVING FREEMAN		M.D. Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/29/58		22c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight Inc.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 5 '58		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>	
VS A15 (4) ISM 10/57							
Wm. Cook-Blight, Inc., 6009 Harford Rd., Baltimore, Md.							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7703 CERTIFICATE OF DEATH

0768
32

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE CITY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 900 CATHEDRAL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS LANHAM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES		First	Middle	Lost	4. DATE OF DEATH 7	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/92	9. AGE (In years last birthday) 65	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 14	12. Year Hours Min 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. ARMY		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES E. LANHAM		14. MOTHER'S MAIDEN NAME ROSA SCHAEFFER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> YES		16. SOCIAL SECURITY NO. 236-68-2875		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COPD DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SPONTANEOUS PNEUMOTHORAX								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mt. Wilson, Maryland	(County)	(State)
21. I certify that I attended the deceased from 6/25 , 1958, to 7/14 , 1958, that I last saw the deceased alive on 7/14 , 1958, and that death occurred at 12:54 PM , from the causes and on the date stated above								
ADDRESS (Street, city or town, state) Mt. Wilson, Maryland								
DATE SIGNED								
ACTUAL SIGNATURE William Newcomer		M.D. Superintendent						
PHYSICIAN'S NAME (Type) William Newcomer, M.D.								
22a. BURIAL REMAINTION, REMOVE <input type="checkbox"/> SPECIFY 9-17-58 Baltimore		22b. DATE THEREOF 7-17-58		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (Town, or county) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE W. Kelly Funeral Home		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 17 '58		24b. REGISTRAR'S SIGNATURE Albert		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. If either, 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07689									
7704 CERTIFICATE OF DEATH										Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY BALTIMORE					MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS					c. LENGTH OF STAY IN 1b					a. STATE Maryland									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood STATE Training School					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gathertown					b. COUNTY Montgomery									
3. NAME OF DECEASED (Type or print) ROBERT					First		Middle		Lost		4. DATE OF DEATH LAYMAN	Month JULY	Day 3	Year 1958					
5. SEX M		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/24		9. AGE (In years lost birthday) 33 yrs		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____					10b. KIND OF BUSINESS OR INDUSTRY _____					11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY U.S.A.						
13. FATHER'S NAME HAWES, Robert					14. MOTHER'S MAIDEN NAME LAYMAN, MAUDE					Address Rosewood Records									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) No										16. SOCIAL SECURITY NO. —		17. INFORMANT ROSEWOOD RECORDS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 364X										Bronchopneumonia, Aspiration		2 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia & hypostasis compression of cervical and										Guillain-Barre Synd. (inf. polyradiculitis)		1/2 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Glenemalgrephitis due to osteomyelitis of vertebrae										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter notes of injury in Part I or Part II of item 18.) 471X														
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md						
21. I certify that I attended the deceased from JUNE 6 , 19 58 , to July 3 , 19 58 , and that death occurred at 635 M, from the causes and on the date stated above										ADDRESS (Street, city or town, state) 7/3/58									
ACTUAL SIGNATURE R. Rich. Lindenborg (Physician) 700 Fleet Street										DATE SIGNED 7/3/58									
PHYSICIAN'S NAME (Type) Rich. Lindenborg					22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF July 6 1958		22c. NAME OF CEMETERY OR CREMATORIUM Captownsville Md Montgomery		22d. LOCATION (City, town, or county) 277					
23. FUNERAL DIRECTOR'S SIGNATURE Poy W Barber Captownsville Md					ADDRESS Captownsville Md Montgomery		24a. REC'D BY REGISTRAR Jul 10 1958		24b. REGISTRAR'S SIGNATURE Alt. esuch										

48/2819

A 2 C କୁଳାର୍ମା

ପିଲାଇ ଜିଲ୍ଲା, ନାମିବା
କୁଳାର୍ମା ଗ୍ରାମରେ

T 930123WPA

on

various

କିମ୍ବା କିମ୍ବାକି

କିମ୍ବାକି ପାଇଁ କିମ୍ବାକି

କିମ୍ବାକି (କିମ୍ବାକିକିମ୍ବାକି). କିମ୍ବାକି କିମ୍ବାକି

କିମ୍ବାକିକିମ୍ବାକି

1982 23MAY 82 2 plot

1
B
S
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7705 CERTIFICATE OF DEATH

Reg. Dist. No.

07690

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this page has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. If pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 413 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) CHARLIE		First (MM)	Middle LEE
4. DATE OF DEATH JULY 5 1958	Month JULY	Day 5	Year 1958
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 7, 1916
9. AGE (In years from birthday) 42	10. IF UNDER 1 YEAR Months 42	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	14. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	15. BIRTHPLACE (State or foreign country) NORTH CAROLINA	16. CITIZEN OF WHAT COUNTRY U.S.A.
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <input checked="" type="checkbox"/> YES	18. SOCIAL SECURITY NO W-11	19. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND	Address
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA, CONGESTION AND BRONCHO PNEUMONIA +43X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO VASCULAR DISEASE DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SUB ACUTE GLOMERULONEPHRITIS			
ABOUT 2 YRS.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH Fort Howard Maryland
20f. (City or town) Fort Howard		(County) Baltimore	
		(State) Maryland	
21. I certify that I attended the deceased from May 18, 1957 , to July 5, 1958 , that deceased died in Fort Howard , and that death occurred at 3:45 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Fort Howard, Maryland			
DATE SIGNED 7-6-58			
ACTUAL SIGNATURE <i>Chien Wei Ian</i>		M.D. VAH Fort Howard Maryland	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN		M.D. VAH Fort Howard Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-9-58	22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL
22d. LOCATION (City, town, or county) BALTIMORE, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE EIROY O WILSON		ADDRESS 1000 Brantley Avenue Baltimore, Md.	24a. REC'D BY REGISTRAR DATE JUL 7 '58
		24b. REGISTRAR'S SIGNATURE <i>Av. esch</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

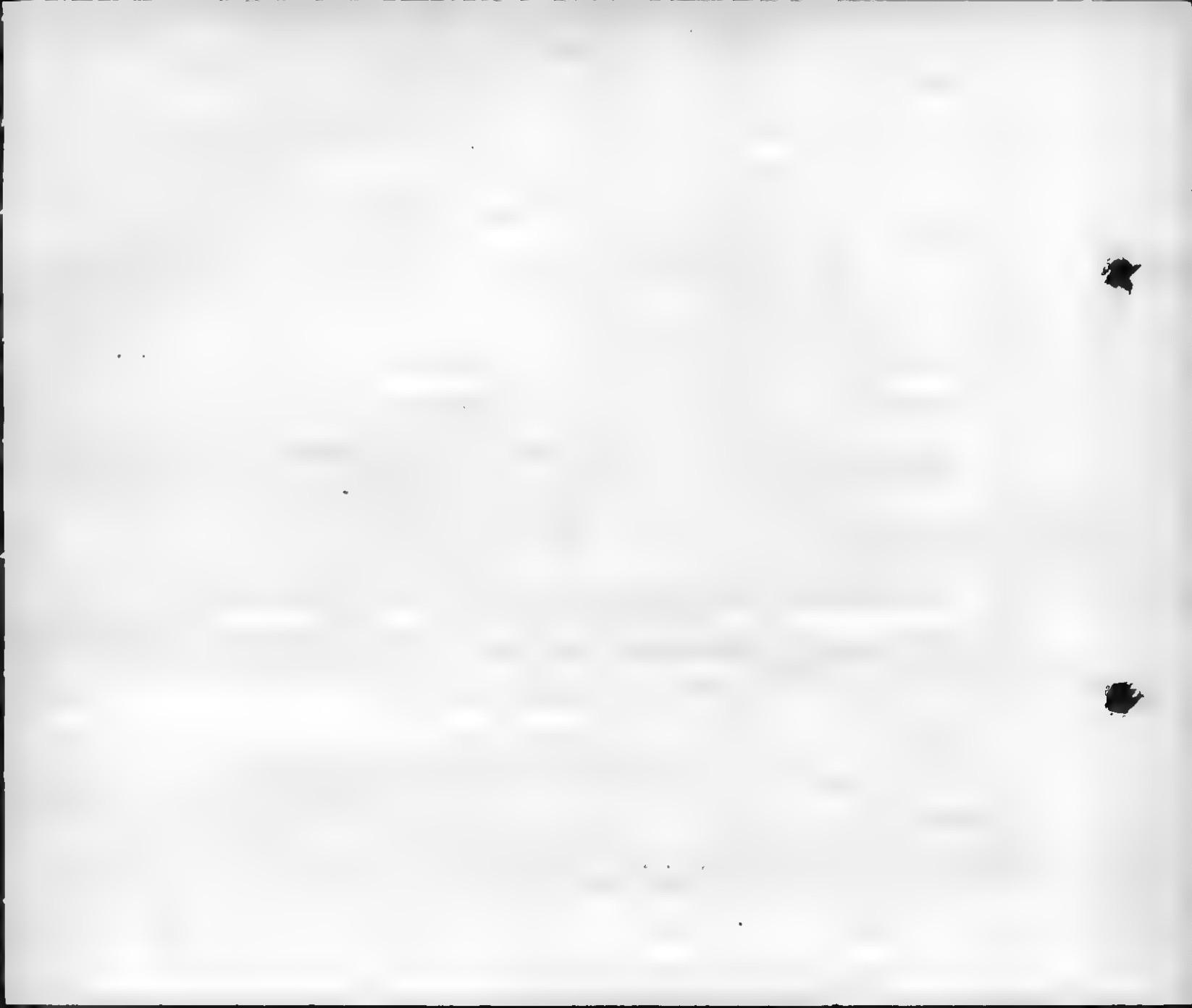
7706

CERTIFICATE OF DEATH

07691

Reg. Dist. No.

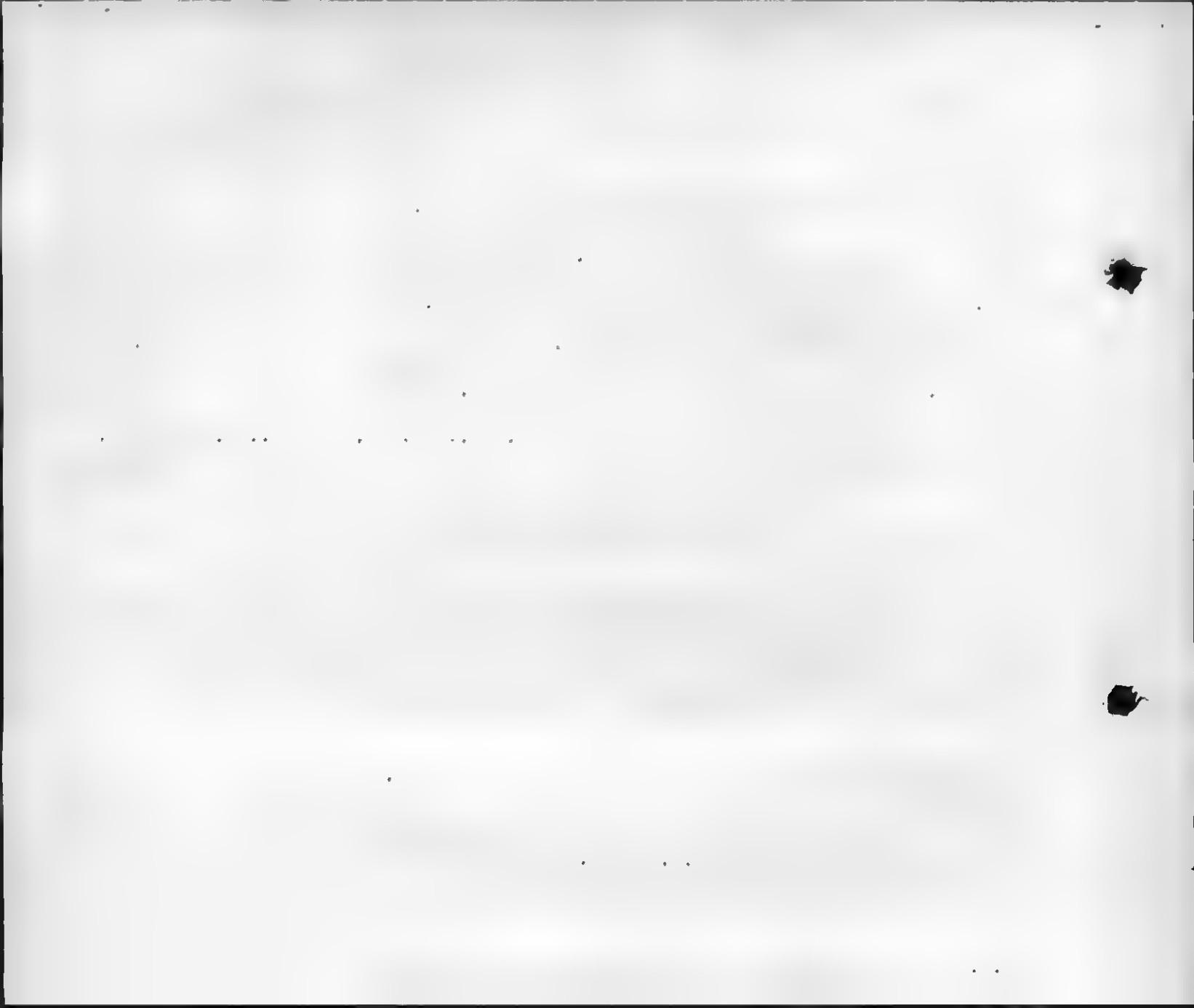
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
<i>Baltimore County</i> <i>8318 Hillendale Rd.</i>		a. STATE <i>Md.</i> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Md.</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Md.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS <i>8318 Hillendale Rd.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Sarah</i>	Middle <i>V.</i>	Last <i>Loffus</i>	4. DATE OF DEATH <i>July 17-1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24-1894</i>	9. AGE (in years at birthday) yrs 106
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchandise Pur. Woolworth Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Md.</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Michael Loffus</i>		14. MOTHER'S MAIDEN NAME <i>Sarah O'Brien</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>213-03-0530</i>	17. INFORMANT <i>Martin J. Loffus, 8318 Hillendale Rd.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1650.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Cause of death <i>Conway occlusion arquebuse</i>		
		INTERVAL BETWEEN ONSET AND DEATH <i>7 weeks</i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>No</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>May 24, 1958, to June 28, 1958</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore Md.</i>	20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>May 28</i> , 1958, to <i>June 28</i> , 1958, that I last saw the deceased alive on <i>June 28</i> , 1958, and that death occurred at <i>6:35 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Milton B. Kress</i> DATE SIGNED <i>7/18/58</i>		
ACTUAL SIGNATURE <i>Milton B. Kress</i>		PHYSICIAN'S NAME (Type) <i>Milton B. Kress, M.D.</i> Medical Arts Building Baltimore 1, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 7-21-59</i>		22b. DATE THEREOF <i>July 21-59</i>	22c. NAME OF CEMETERY, OR CREMATORIUM <i>New Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Miller</i>		ADDRESS <i>24318 Olney St.</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Westmore</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										117692	
7707 CERTIFICATE OF DEATH					Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 3 Days					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia d. STREET ADDRESS 2853 N. Orianna Street						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES		First	Middle	Last	4. DATE OF DEATH July		Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1887		9. AGE (In years lost birthday) yrs. 71		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man-Retired		10b. KIND OF BUSINESS OR INDUSTRY Electric Dept.		11. BIRTHPLACE (State or foreign country) Valley Lee, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME John F. Lumpkins					14. MOTHER'S MAIDEN NAME Ann E. Pilkerton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> <small>(Do not check if no or unknown)</small>		16. SOCIAL SECURITY NO 160-10-8024		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		<small>Address</small>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										<small>INTERVAL BETWEEN ONSET AND DEATH</small> 13 DAYS	
PART I. DEATH WAS CAUSED BY. <small>IMMEDIATE CAUSE (a)</small> CEREBRAL VASCULAR ACCIDENT <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> <small>(b)</small> ARTERIOSCLEROSIS, GENERALIZED <small>DUE TO</small> <small>(c)</small>											
<small>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</small> HYPERTENSIVE CARDIOVASCULAR DISEASE										<small>19. WAS AUTOPSY PERFORMED?</small> <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> <small>OR CONTRIBUTING</small> <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, FORT HOWARD, MARYLAND		20f. (City or town) Valley Lee, Maryland		<small>(County)</small> <small>(State)</small>			
21. I certify that X I attended the deceased from July 22, 1958 , to July 25, 1958 . that death occurred at 2:30A.M. , from the causes and on the date stated above. <small>ADDRESS (Street, city or town, state)</small> <small>DATE SIGNED</small>											
<small>ACTUAL SIGNATURE</small> <i>Irving Freeman</i>		<small>MD</small> VAH, FORT HOWARD, MARYLAND									
<small>PHYSICIAN'S NAME (Type)</small> IRVING FREEMAN, M.D., Chief, Medical Service		<small>7/25/58</small>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/58		22c. NAME OF CEMETERY OR CREMATORIUM Poplar Hill Cemetery		22d. LOCATION (City, town, or county) Valley Lee, Maryland		<small>(State)</small>			
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley		ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR 28 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7708

CERTIFICATE OF DEATH

07693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore MARYLAND		Catonsville		2 years months		a. STATE Maryland	
						b. COUNTY Charles Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				La Plata, Maryland		La Plata, Maryland	
3. NAME OF DECEASED (Type or print)		First Mary	Middle Murphy	Last Lynch	4. DATE OF DEATH	Month July 22	Day Year 1958
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH August 19, 1887	9. AGE (In years less birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
widowed <input checked="" type="checkbox"/>		divorced <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Murphy		14. MOTHER'S MAIDEN NAME Mary Eliz. Duchett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Generalized arteriosclerosis					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1956, to July 22, 1958, that I last saw the deceased alive on July 22, 1958, and that death occurred at 5:45 a. m., from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL 7-22-58					
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/58		22c. NAME OF CEMETERY OR CREMATORIAL Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Tolson Son		ADDRESS 318 Light		24a. REC'D BY REGISTRAR DATE JUL 24 '58		24b. REGISTRAR'S SIGNATURE A. W. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



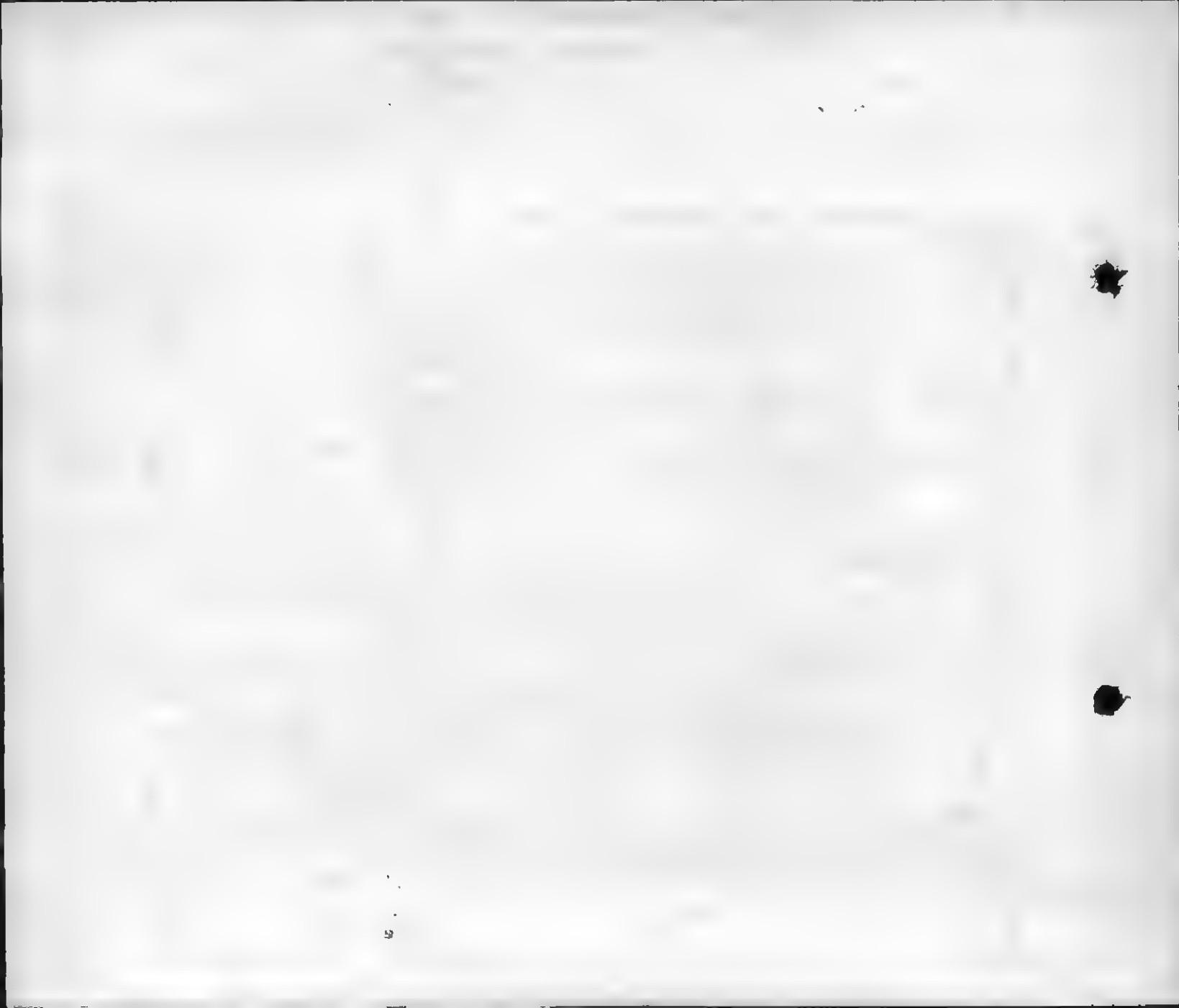
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7709 Item 271-1-50 et
CERTIFICATE OF DEATH

07694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Baltimore		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN Tb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Catonsville	-	Catonsville, Md., Chesapeake	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
House in the Pines	Highway Rd., ---		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Bertha	H	Maberry	7
4. DATE OF DEATH	Month	Day	Year
7	4	1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Fem	Cauc		80 30 May 18 28
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
78	Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Delaware	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John Wm H	Ida Horns		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
No	(If yes, give war or date of service)	Wm H Maberry	Hughsville Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			5da.
Broncho-Pneumonia			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first.			(b)
DUE TO			(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED?
Generalized arteriosclerosis			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from 3-31, 1958, to 7-3 - 1958, that I last saw the deceased alive on 7-8 - 1958, and that death occurred at 4:00 A.M. from the causes and on the date stated above.			ADDRESS (Street, city or town, state)
			DATE SIGNED
ACTUAL SIGNATURE	Wilmer K. Gallagher		M.D. 6209 Frederick Ave. 7-9-58
PHYSICIAN'S NAME (Type)	Wilmer K. Gallagher		Baltimore 28, Md.
22a. BURIAL, CREMATION: REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	July 11, 1958	Lakeside Cemetery	Dover, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Easton Sons Catonsville Md.		JUL 16 '58	Alt. couch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07695

7710

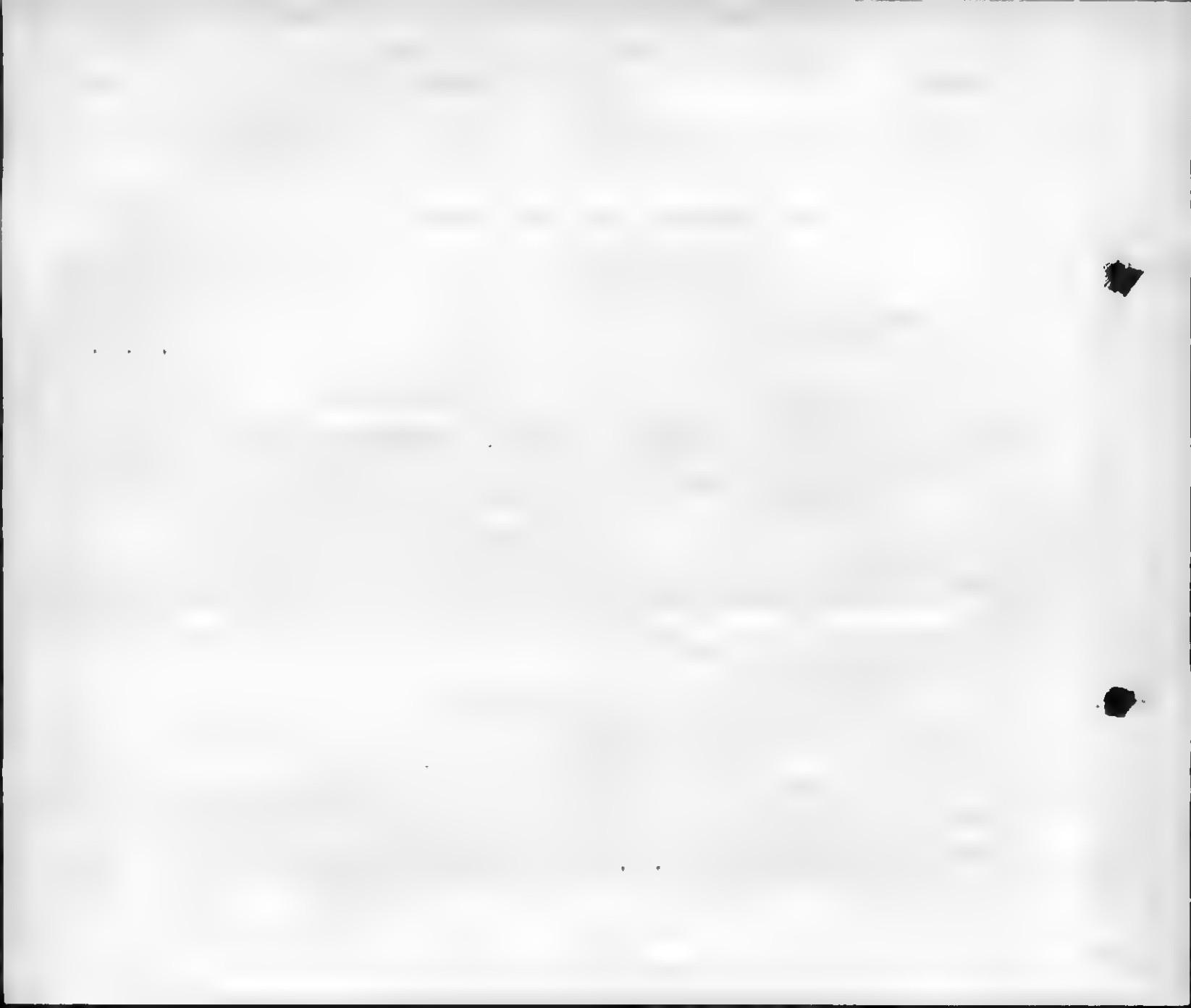
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr 5mth 9dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 5024 Mineola Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Junuietta	Middle Sherwood	Last Mann	4. DATE OF DEATH July 28	Month July	Day 28	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 80?	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stephen Sherwood		14. MOTHER'S MAIDEN NAME Sarah Carpenter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetes mellitus					
20c. TIME OF INJURY Hour a. p.m. p. m.	Month July	Day 11	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL	20f. (City or town) 7-28-58	(County) (State)
21. I certify that I attended the deceased from July 11 , 1958, to July 28 , 1958, that I last saw the deceased alive on July 28 , 1958, and that death occurred at 9:30a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) Catonsville 28, Maryland		DATE SIGNED 7-28-58			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/58	22c. NAME OF CEMETERY OR CREMATORIAL Bridgeman Memorial Funeral Home	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Miss Nefterson	ADDRESS 28	24a. REC'D. BY REGISTRAR JUL 31 '58	24b. REGISTRAR'S SIGNATURE W. J. Keane				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7711 CERTIFICATE OF DEATH

07696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut. or Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 408 Westshire Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Westshire Road				d. STREET ADDRESS 408 Westshire Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ide	Middle E.	Last Martin	4. DATE OF DEATH July 27, 1958	Month July	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 17, 1883	9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Schultheis		14. MOTHER'S MAIDEN NAME Katherine Schwartz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT (SON) Elmer W. Martin, 408 Westshire Rd. Catonsville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral		DUE TO				INTERVAL BETWEEN ONSET AND DEATH 48 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Diabetes Mellitus		(b) DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 206 S. Gilmore St.		20f. (City or town) Baltimore	(County) Md. (State) Md.
21. I certify that I attended the deceased from 4-10-58 , 19_____, to 7-27-58 , 19_____, that I last saw the deceased alive on 7-26-58 , 19_____, and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Nathan Racusin M.D. ADDRESS (Street, city or town, state) 206 S. Gilmore St. DATE SIGNED 7-29-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30/58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Baltimore 29, Md. (State) Md.	
23. FUNERAL DIRECTORS SIGNATURE Nathan Racusin Directors ADDRESS 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE Allie Leach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7712 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (6)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 729 Essex Ave.				d. STREET ADDRESS 1044 Lewood Way	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print)		First William	Middle Riley	Last Mays	4. DATE OF DEATH July 20,	Month 19	Day 58	Year
--	--	-------------------------	------------------------	---------------------	-------------------------------------	--------------------	------------------	------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1877	9. AGE (In years less birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 MRS. Hours 0	13. IF UNDER 24 MIN. 0
-----------------------	----------------------------------	--	--	--	---	--	---	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	---

13. FATHER'S NAME William Mays	14. MOTHER'S MAIDEN NAME Marial Cash
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-20-5621	17. INFORMANT Clyde Mays Same	Address
--	---	---	---------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 44x		<i>Cardio vascular renal dis.</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { b }		
DUE TO cause last. { c }		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	--	--	---

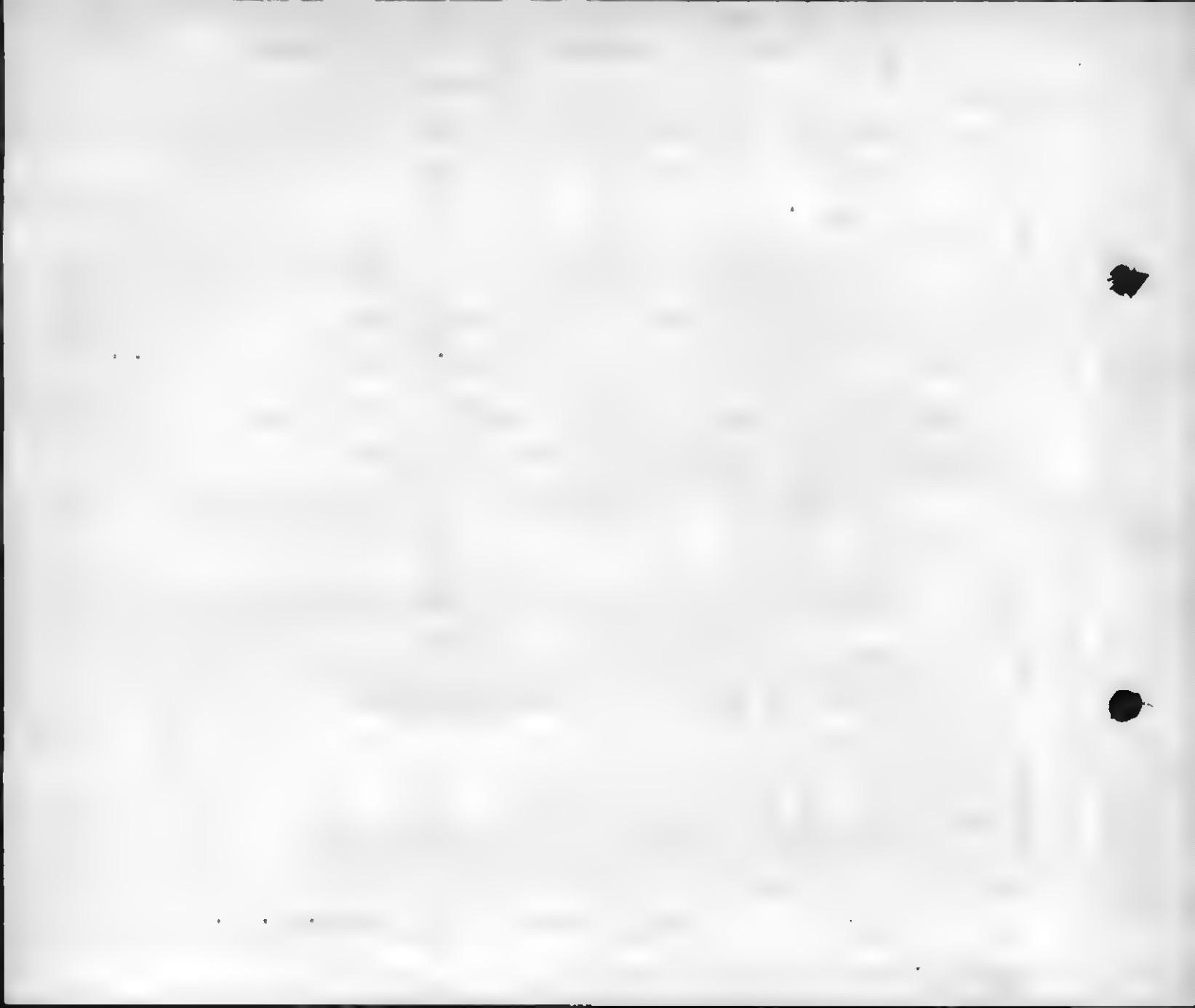
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
---	-------------------------------	---	---	--

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
--	--	--	--	--	--

ACTUAL SIGNATURE <i>Jack McCallum</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 7-20-58
EXAMINER'S NAME (Type) James E. Brudzinski		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/58	22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	22d. LOCATION (City, town, or county) Balto. Co. Md.
--	-------------------------------------	--	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Brudzinski</i>	ADDRESS 1407 Eastern Ave.	24a. REC'D BY REGISTRAR JUL 23 '58	24b. REGISTRAR'S SIGNATURE Debrauch
--	-------------------------------------	--	---



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

V3 A15
6M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07698

		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY BALTL.		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD b. COUNTY BALTL.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BENDALE		c. LENGTH OF STAY IN lb 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 ST. HELENA AVE		d. STREET ADDRESS 225 ST. HELENA AVE	
3. NAME OF DECEASED (Type or print) CHESTER ADAM McCARTY		First	Middle
4. DATE OF DEATH 7/23/58		Month	Day
5. SEX MALE		6. COLOR OR RACE LWHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 18 JUNE 1914
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 57 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SANITARY FIXTURES	
11. BIRTHPLACE (State or foreign country) KY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CEC. S. McCARTY		14. MOTHER'S MAIDEN NAME BERTHA MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 411-63-9957	
(If yes, give war or dates of service)		17. INFORMANT HANNAH J. McCARTY - SISTER	
Address		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stealing the underlying cause lost. DUE TO (c)		Strongulation by hanging	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack Collins		DATE SIGNED 7/26/58	
EXAMINER'S NAME (Type) JACK COLLINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL/CREMATION/REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/25/58	
22c. NAME OF CEMETERY OR CREMATORIAL ELDERBEEF		22d. LOCATION (City, town, or county) FELVISVILLE, KY (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR JUL 29 '58		24b. REGISTRAR'S SIGNATURE Mr. Cohen	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7713

CERTIFICATE OF DEATH

07699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Baltimore City MARYLAND		a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Baltimore	3 days	Cockeysville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
Daughter's home Baltimore Mill Rd.	Leaver Dam Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
Mary			McDermott	
4. DATE OF DEATH	Month	Day	Year	
	July	5	1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	
Female	White		APRIL 1, 1879	
9. AGE (In years (last birthday) yrs.)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
79				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY	
Housewife	-	Warrington England	11517	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
John McKnight	Elizabeth Hyland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
No	None	Regina A. Parish	Baldwin Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	cardiac decom sensitivis 2415			
422.1	DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	(b)	arteria sclerotic cardio (asculactus) 3415		
DUE TO				(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			11517	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, M, from the causes and on the date stated above.				
ACTUAL SIGNATURE		ADDRESS (Street, city, or town, state) DATE SIGNED Cockeysville, Md 7-8-58		
PHYSICIAN'S NAME (Type) WALTER T. KEES				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIY	22d. LOCATION (City, town, or county)	(State)
BURIAL	JULY 11, 1958	ST. JOSEPH'S CHURCH	TEAS MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
John Burns Lewis	Towson 4, Md.	JULY 11 '58	Deleach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



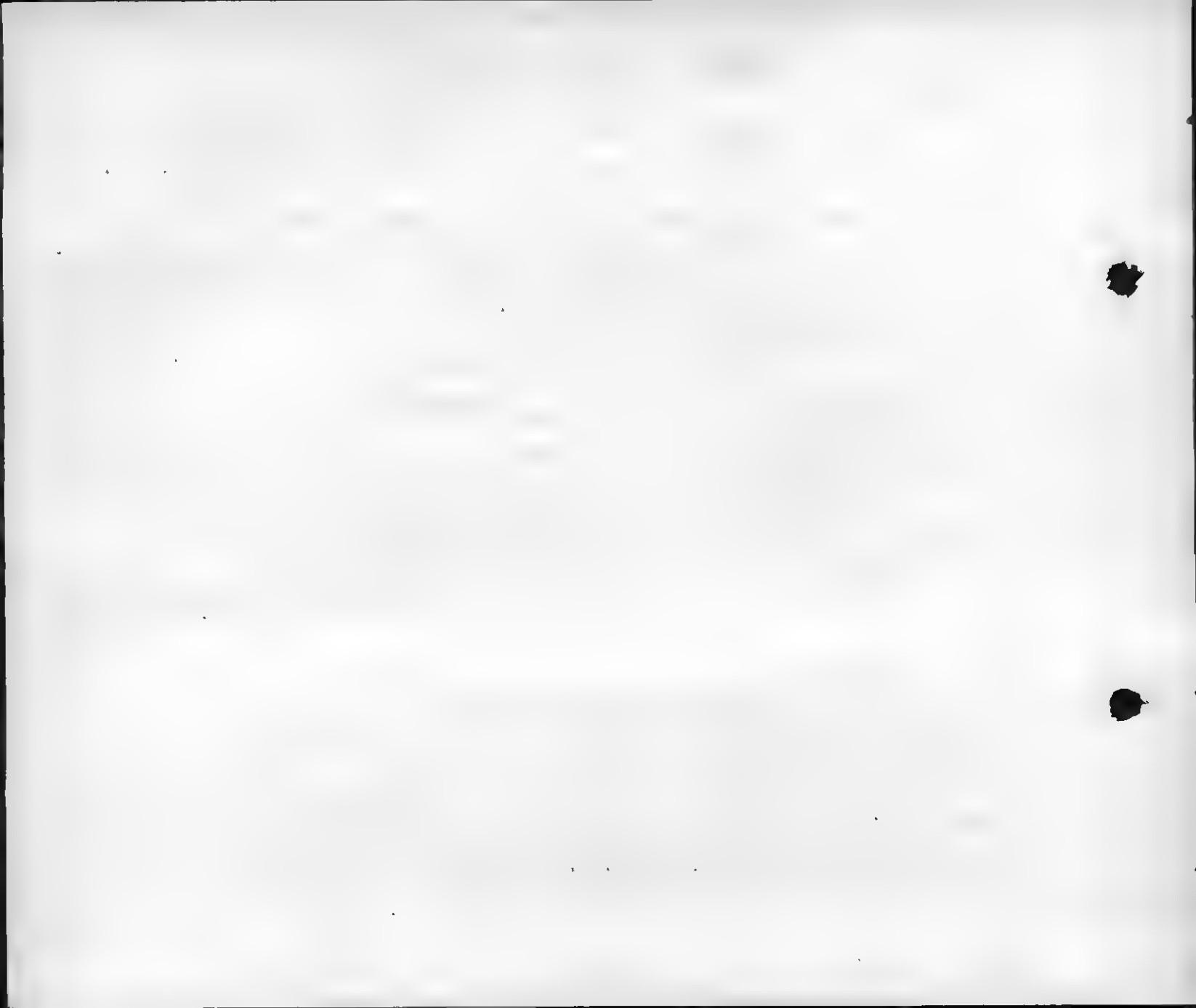
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07700

7714 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mths23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Walter	Middle Leslie	4. DATE OF DEATH Month July Day 1 Year 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Nov. 19, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert McElwain		14. MOTHER'S MAIDEN NAME Florence Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO 216-38-2525	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and dehydration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic brain disease DUE TO Arteriosclerotic cardiovascular disease (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 25 , 1958, to July 1 , 1958, that I last saw the deceased alive on July 1 , 1958, and that death occurred at 5:00a.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Gertrude J. Fleischmann</i> SPRING GROVE STATE HOSPITAL 7-1-58 DATE SIGNED PHYSICIAN'S NAME (Type) Gertrude Fleischmann, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-4-58	22c. NAME OF CEMETERY OR CREMATORIUM CENTRE PRESBY.	22d. LOCATION (City, town, or county) NEW YORK, YORKE, PA. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth W. Lusk</i>	ADDRESS Stevatoburn, Pa.	24a. REC'D BY REGISTRAR DATRIL 3 '58	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7715 CERTIFICATE OF DEATH

Reg. Dist. No.

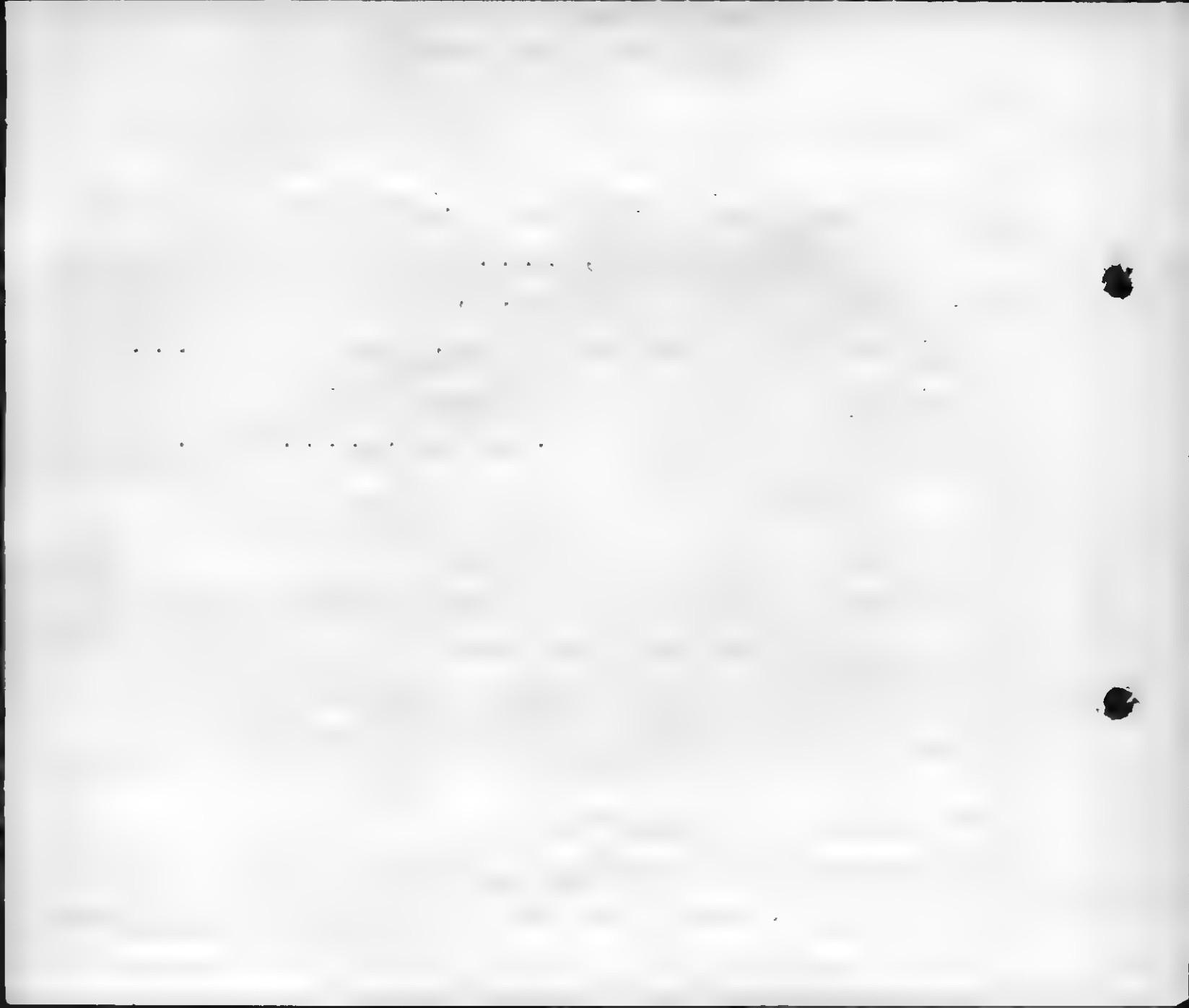
07701

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6401 N. Charles Street			c. LENGTH OF STAY IN 1b 41 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION School Sisters of Notre Dame Motherhouse			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Catherine	Middle Frances	Last Mees	4. DATE OF DEATH Month July Day 28 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb. 12, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Teacher			10b. KIND OF BUSINESS OR INDUSTRY Religious	11. BIRTHPLACE (State or foreign country) Maintz, Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Francis Mees			14. MOTHER'S MAIDEN NAME Elizabeth Pfenning		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT Sr. Mary Ernest, S.S.N.D. Address 6401 N. Charles St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral failure DUE TO (c) Arterio - sclerotic hypertension CVD			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1952 to July 29, 1958 , that I last saw the deceased alive on July 27, 1958 , and that death occurred at 1120 St. Paul St. from the causes and on the date stated above. ACTUAL SIGNATURE Vincent de Paul Fitzpatrick ADDRESS 1120 St. Paul St. DATE July 29, 1958					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Villa Maria Notch Cliff	
22d. LOCATION (City, town, or county) Glenarm		22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Laura E. Smith			24a. REC'D BY REGISTRAR DATE JUL 29 '58		
ADDRESS 4905 York St.			24b. REGISTRAR'S SIGNATURE A. L. Leach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07702

CERTIFICATE OF DEATH

Reg. Dist. No.

7716

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN lb 14 Hours 30 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2826 Rayner Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JAMES	Middle E.	Last MORRISEY	4. DATE OF DEATH July 27 1958	Month July	Day 27	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1906	9. AGE (In years last birthday) 52 56 yrs	10. IF UNDER 1 YEAR Months 52 56 yrs	11. IF UNDER 24 HRS Hours 52 56 hrs	12. IF UNDER 24 HRS Min 52 56 min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Edward Morrisey				14. MOTHER'S MAIDEN NAME Anna Matthews				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 240-12-6634		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ARTERIOLAR NEPHROSCLEROSIS								
INTERVAL BETWEEN ONSET AND DEATH 5 WEEKS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 9:15 AM 7/27 1958 , to 11:45 PM 7/27 1958 , and that death occurred at 11:45 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE <i>Chien Wei Lan</i>	M.D.		VAH, FORT HOWARD, MARYLAND		DATE SIGNED 7/28/58			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.	VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/29/1958	22c. NAME OF CEMETERY OR CREMATORIUM Morrisey & McCallum Cemetery		22d. LOCATION (City, town, or county) Turkey, North Carolina		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808-10 N. Monroe St., Balt.		ADDRESS 1808-10 N. Monroe St., Balt., Md.		24a. REC'D BY REGISTRAR UL 31 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>		
SHIPPED TO: L.E.Garris Funeral Home, Mt. Olive, N.C.								

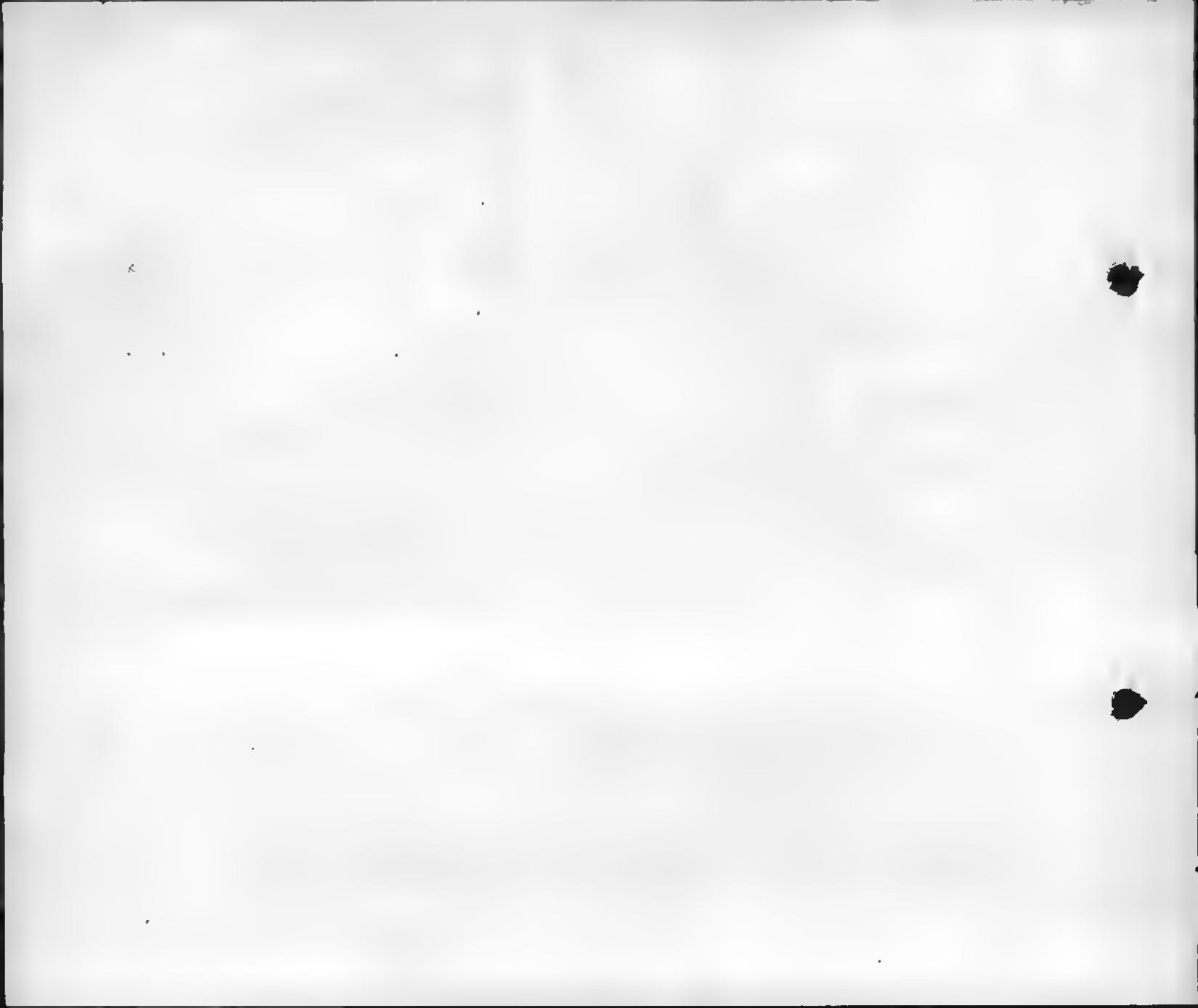


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7717 CERTIFICATE OF DEATH**

07703

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN lb 9mths 17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Relay			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 5009 Hazel Avenue			
3. NAME OF DECEASED (Type or print) female Mildred		First Middle Grace Morrison		4. DATE OF DEATH Month July Day 21 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX female white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1890	
9. AGE (In years last birthday) 67 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Penns.	
						12 CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Randolph Rush				14. MOTHER'S MAIDEN NAME Martha Craft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, general, severe DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21, 1958, to July 21, 1958, that I last saw the deceased alive on 3/4, 1958, and that death occurred at 3:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) STELLA NACHSLER		DATE SIGNED 7/21/1958 SPRING GROVE STATE HOSPITAL					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/24/58		22c. NAME OF CEMETERY OR CREMATORIAL ?		22d. LOCATION (City, town, or county) Prosperity, Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. M. Schaeffer		ADDRESS 11 N. Main St. Catonsville 28, Maryland		24a. REC'D BY REGISTRAR DATE JUL 23 '58		24b. REGISTRAR'S SIGNATURE A. Schaeffer	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. The burial-transit permit, then please remove carbon papers. The registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7718

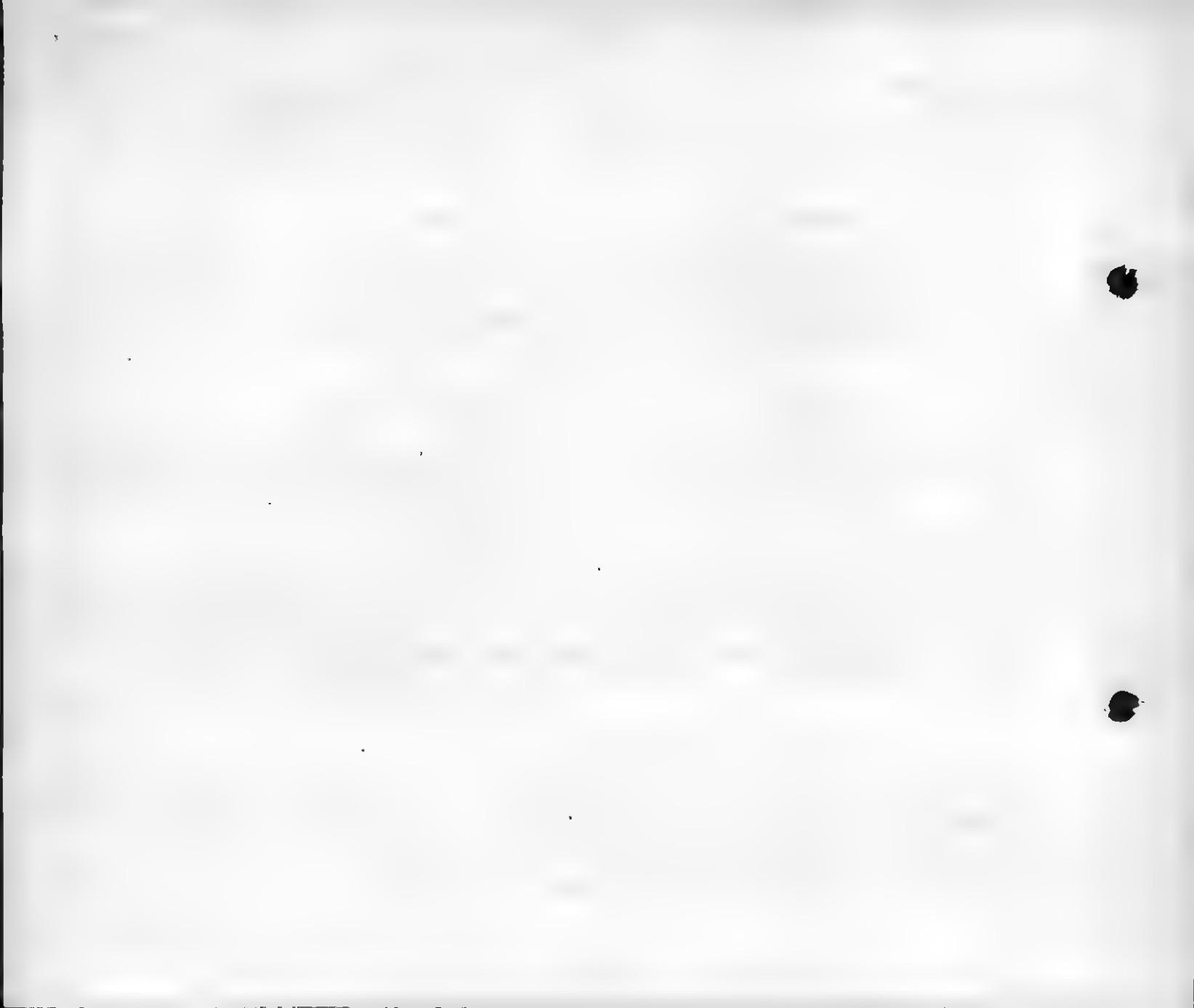
CERTIFICATE OF DEATH

Item 5, Form 232, 3/17/58, 991

07704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Dulaney Valley		c. LENGTH OF STAY IN lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Dulaney Valley			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION 500 Stratford Court		d. STREET ADDRESS 500 Stratford Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frieda Mueller	Middle	Last	4. DATE OF DEATH	Month July	Day 31	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Seufger		14. MOTHER'S MAIDEN NAME Mitilda Schmidt		Address Charolette M. Schafer 500 Stratford Court			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Charolette M. Schafer		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 165X DUE TO Cirrhosis of Liver.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { b)		DUE TO c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred on _____, 19_____. M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Actual Signature: Frieda Mueller, M.D. 3358 Wachtertown Rd. Baltimore, Maryland DATE SIGNED 8/2/58					
ACTUAL SIGNATURE Frieda Mueller, M.D. 3358 Wachtertown Rd. Baltimore, Maryland							
PHYSICIAN'S NAME (Type) Frieda Mueller, M.D. 3358 Wachtertown Rd. Baltimore, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-2-1958	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home 7401 Belair Rd.		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE AUG 4 '58	24b. REGISTRAR'S SIGNATURE Albert Beach		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07705

Reg. Dist. No.

7719

To DEPUTY MEDICAL EXAMINER: Please enter in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by the funeral director. Page 4 should be filed in our files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISM(E) 5
SM 9/55

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTO—				c. LENGTH OF STAY IN lb 8 yes			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2926 Cub Hill Rd.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Baltimore—Carney			
3. NAME OF DECEASED (Type or print) Hector Rudolph Muhlhahn				4. DATE OF DEATH July 31 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 28 Mar 1898		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Balto. Catering Co.			
11. BIRTHPLACE (State or foreign country) Balto. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY Muhlhahn				14. MOTHER'S MAIDEN NAME Juliane Wickherlein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-01-2857			
17. INFORMANT Wife Marie Muhlhahn - same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH 1 month?			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)				Myocardial Infarction			
DUE TO (c)				Atherosclerosis and CardioVasc. Disease ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyde				DATE SIGNED 7-31-58			
EXAMINER'S NAME (Type) John C. Hyde				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-1958		22c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Cem.		22d. LOCATION (City, town, or county) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassan Funeral Home 7401 Belair Rd.				ADDRESS		24a. REC'D BY REGISTRAR DATE NUG 4 '58	
						24b. REGISTRAR'S SIGNATURE Q. L. Edwards	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7720 CERTIFICATE OF DEATH

Reg. Dist. No.

07706

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bengies	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bengies	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 19, Route 15, Balto. 20, Md.		d. STREET ADDRESS Box 19, Route 15, Balto. 20, Md.	
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle NENADAL	4. DATE OF DEATH July 17, 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1876
			9. AGE (In years at birthday) 82 yrs.
			10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Variety Store		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Czechoslovakia
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	17. INFORMANT Antonia Palivec Nenadal, wife, above Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive thrombosis venous DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1958, to 7/17, 1958, that I last saw the deceased alive on 7/17, 1958, and that death occurred at 9 B. M. from the causes and on the date stated above. ACTUAL SIGNATURE J. PLATT, M.D. PHYSICIAN'S NAME (Type) J. PLATT, M.D.		ADDRESS (Street, city or town, state) 434 Eastern Ave Ealy md. DATE SIGNED 7/19/58	
22a. BURIAL CREMATION REMOVAL (check) Burial	22b. DATE THEREOF 7/21/58	22c. NAME OF CEMETERY OR CREMATORIAL Bohemian National Cem	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane		24a. REC'D BY REGISTRAR DATE JUL 21 '58	24b. REGISTRAR'S SIGNATURE Ave. Schimunek



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07708

7721

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbrook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbrook	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6302 N. Charles St.		d. STREET ADDRESS 6302 N. Charles, St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNIE		First T.	Middle O'MALLEY
4. DATE OF DEATH July 12 1958		Month July	Day 12
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 22, 1885		9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Brayden		14. MOTHER'S MAIDEN NAME Margaret Durkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes or no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	
17. INFORMANT Mrs Frank T. Hogan - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension P-V Disease Generalized arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1957 , to July 12, 1958 , that I last saw the deceased alive on July 1, 1958 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 620 York	
ACTUAL SIGNATURE Charles L. Smith M.D.		DATE SIGNED 7/13/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery		22d. LOCATION (City, town, or county) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkinson Sons Co.		ADDRESS 4905 York Road	
		24a. RECD BY REGISTRAR JUL 15 '58	
		24b. REGISTRAR'S SIGNATURE W. J. Jenkinson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7722

CERTIFICATE OF DEATH

07709

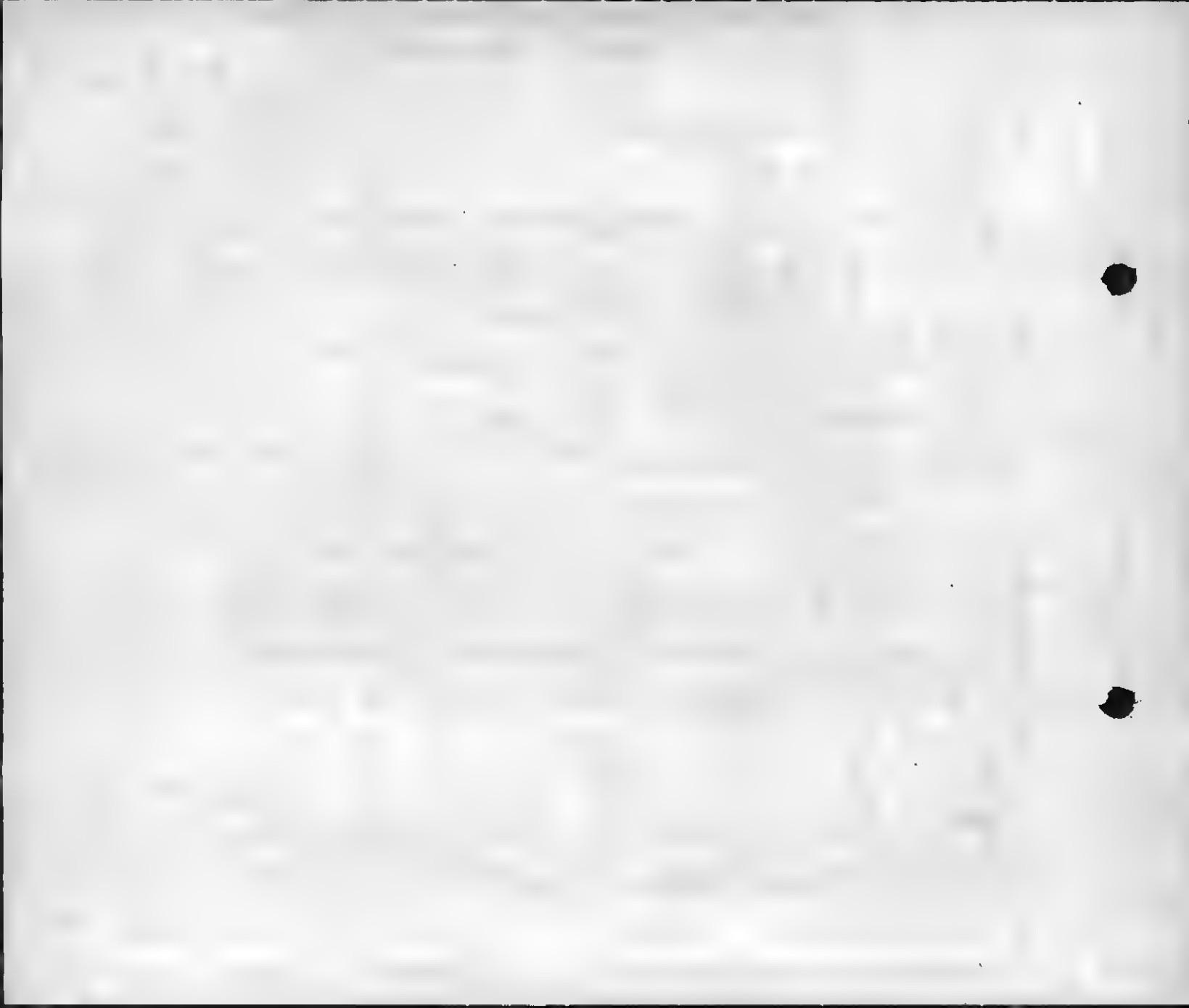
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catoonsville</i>	c. LENGTH OF STAY IN 1b <i>5 mo</i>	b. COUNTY <i>Glen Burnie</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 30</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Woods, Stone</i>		d. STREET ADDRESS <i>121 Scott Street</i>	
3. NAME OF DECEASED (Type or print) <i>Wm. K. Gallagher</i>		4. DATE OF DEATH <i>9/20/58</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S SEX <i>Male</i>	5. COLOR OF HAIR <i>Black</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>9/22/1887</i>
8. AGE (In years lost birthday) <i>70 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	10. IF UNDER 24 HRS. Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baltimore at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Budget Sheehan</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Ireland</i>	
13. FATHER'S NAME <i>James K. Gallagher</i>		14. MOTHER'S MAIDEN NAME <i>Budget Sheehan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>133-00-0000</i>	
17. INFORMANT <i>James K. Gallagher 604 Jefferson St. (25)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Hypertension Cardiot-Vascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-28</i> , 19 <i>58</i> , to <i>7-20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7-19</i> , 19 <i>58</i> , and that death occurred at <i>9:45 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wm. K. Gallagher</i> PHYSICIAN'S NAME (Type) <i>Wm. K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>Baltimore 28, Md.</i> DATE SIGNED <i>7-20-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/23/58</i>	
22c. NAME OF CEMETERY OR Crematory <i>New Bethlehem #300</i>		22d. LOCATION (City, town, County) <i>Baltimore 28, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Brown, Son & Sons, Bellisett</i>		24a. REC'D BY REGISTRAR DATE JUL 22 '58	
ADDRESS <i>133-00-0000</i>		24b. REGISTRAR'S SIGNATURE <i>Allen</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for us the burial/transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/53



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07710

7723 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		d. STREET ADDRESS 52 MARYLAND AVENUE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle E.	Last PARKS	4. DATE OF DEATH JULY 2 1958	Month JULY	Day 2	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 1, 1892	9 AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) HOLLANDS ISLAND, MARYLAND				
13. FATHER'S NAME WILLIAM WILEY PARKS		14. MOTHER'S MAIDEN NAME ROSA MC COY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 216-32-9771		17. INFORMANT Clin. Records, Vet. Adm. Hosp. Fort Howard, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		THROMBOSIS LEFT MIDDLE CEREBRAL ARTERY				INTERVAL BETWEEN ONSET AND DEATH 5 WEEKS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state)	(County)	(State)		
21. I certify that I attended the deceased from June 25, 1958 , to July 2, 1958 . The deceased died on the date stated above. I give an affidavit and that death occurred at 6:50 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>W.C. Dudley</i>		M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Grisfield, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE			
BRADSHAW & SONS FUNERAL HOME, CRISFIELD, MD.				III 7 '58	<i>Q.W. Dudley</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use on the burial permit. Then please remove carbon paper. If 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

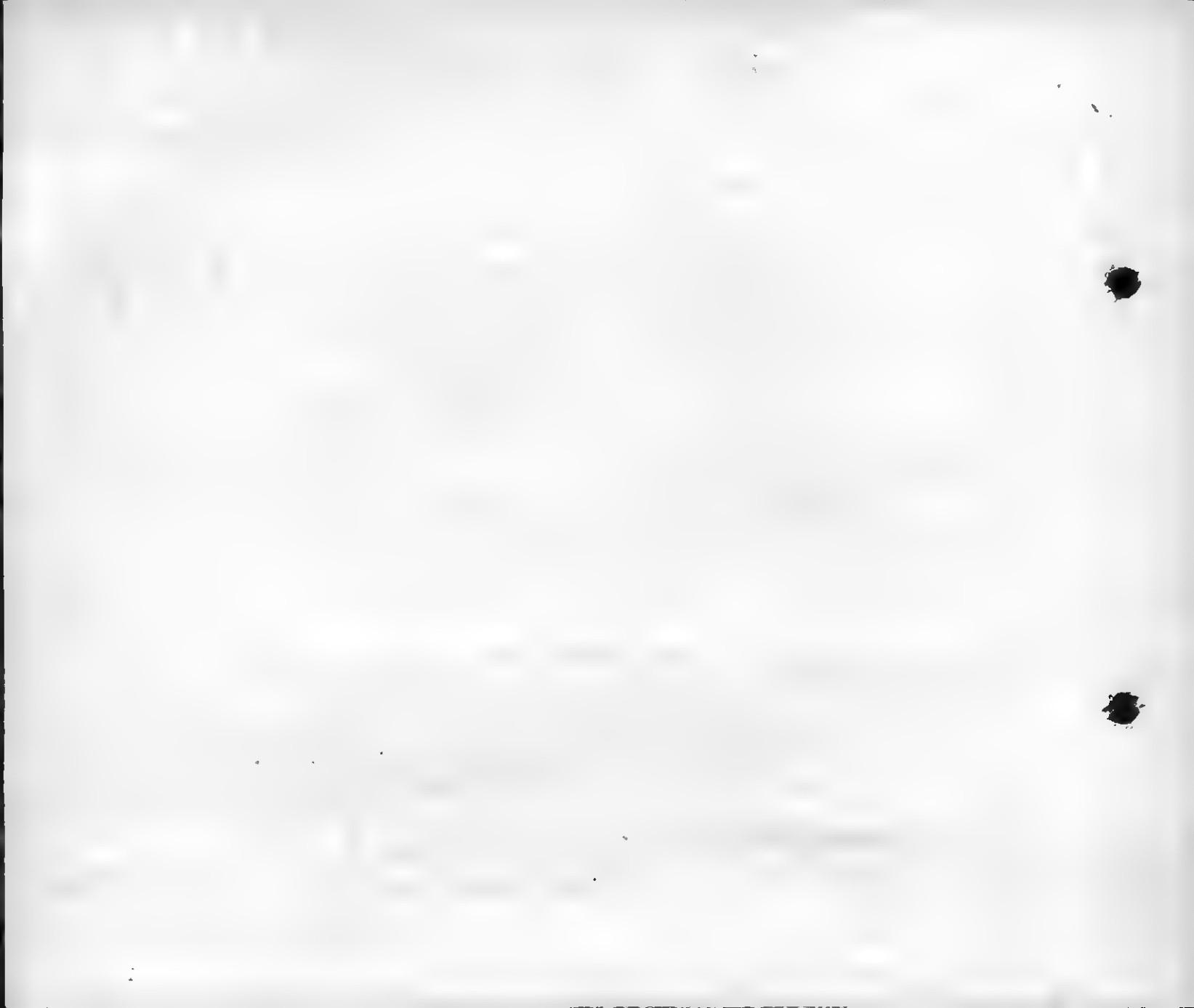
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)			
Baltimore County, MARYLAND		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co.			
c. LENGTH OF STAY IN lb 20 yrs		d. STREET ADDRESS 1219 Dunkirk Road.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nellie	Middle Louise	Last Parsons		
4. DATE OF DEATH	Month July	Day 20	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1876		
9. AGE (In years lost birthday) 81 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY =	11. BIRTHPLACE (State or foreign country) Howard Co., Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Joseph Hobbs				
14. MOTHER'S MAIDEN NAME Isabell Gosnell	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None	17. INFORMANT William H. Parsons - Riderwood, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 100% due to Carcinoma Liver				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 6805 York Rd.	(County) (State)
21. I certify that I attended the deceased from <u>June 10, 1957</u> to <u>July 2, 1958</u> that I last saw the deceased alive on <u>July 2, 1958</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Laurence O. Post</i>	ADDRESS (Street, city or town, state) Baltimore 12 Md				DATE SIGNED
PHYSICIAN'S NAME (Type) LAURENCE O. Post					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 5 1958	22b. DATE THEREOF 1958	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	22d. LOCATION (City, town, or county) Woodlawn	(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Laurence O. Post	ADDRESS 1219 Dunkirk Rd.	24a. REC'D BY REGISTRAR DATE JUL 7 '58	24b. REC'D BY STAR'S SIGNATURE Aut. rec'd		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7725

CERTIFICATE OF DEATH

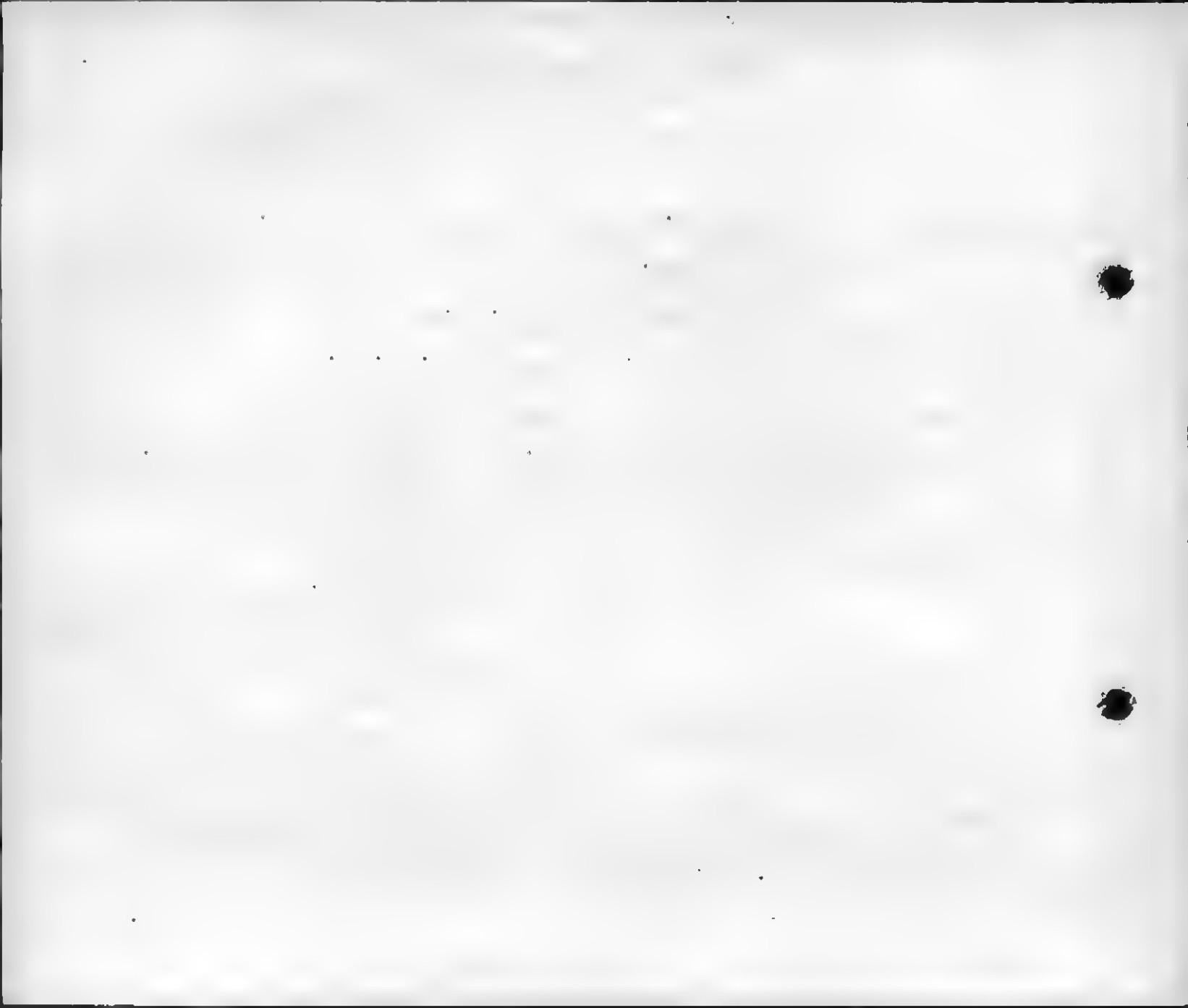
07712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 92 Vincent Rd.	d. STREET ADDRESS Box 92 Vincent Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary E. Petersen	First Middle Last	4. DATE OF DEATH July 14, 1958	Month Day Year
5. SEX Female White	6. COLOR OR RACE WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1878
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Adam Winkler		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Mrs. Frank Jimick 3341 Moravia Ave. 14
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO		Heart Disease - Arteriosclerosis, chronic	
(c) DUE TO		Cerebral Thrombosis, chronic	
		Generalized Arteriosclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. — p.m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 23, 1958, to July 14, 1958, that I last saw the deceased alive on July 23, 1958, and that death occurred at 12-B M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Irving R. Beck M.D. 901 Eutaw Ave. Baltimore 20 Md.	
ACTUAL SIGNATURE <i>Irving R. Beck M.D.</i>		DATE SIGNED M.D.	
PHYSICIAN'S NAME (Type) Irving R. Beck M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Oaklawn
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	24a REC'D BY REGISTRAR DATE JUL 18 '58 24b REGISTRAR'S SIGNATURE <i>W. Lassahn</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit form. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Bill 5231 7-14-58 et

7726

CERTIFICATE OF DEATH

Reg. Dist. No.

07713

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catoctinville</i>		c. LENGTH OF STAY IN 1b <i>17 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hospital of the Jamesbury Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whittemoreville Baltimore</i>	
3. NAME OF DECEASED (Type or print) <i>Mary</i>		f. DATE OF DEATH <i>7/7/58</i>	
4. SEX <i>Female</i>	5. COLOR OF HAIR <i>white</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>3/3/1884</i>
8. DATE OF DEATH <i>7/7/58</i>	9. AGE (In years last birthday) <i>73 yrs</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>William Mockenrich</i>		14. MOTHER'S MIDDLE NAME <i>Wilgmore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mr Edward Hodges</i>		18. ADDRESS <i>325 S Gaynor St.</i>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Uremia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 mos.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic nephritis</i>		6 yrs	
DUE TO (c) <i>malignant hypertension</i>		2-25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>cerebral hemorrhage</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 1609 Wilkins Ave</i>		20f. (City or town) (County) <i>Balto. 23, Md.</i> (State)	
21. I certify that I attended the deceased from <i>January 1958</i> to <i>July 1958</i> , that I last saw the deceased alive on <i>July 7, 1958</i> , and that death occurred at <i>5:29 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4300 Old Field Rd.</i> DATE SIGNED <i>July 8, 1958</i>			
ACTUAL SIGNATURE <i>H. H. Baylus</i>		PHYSICIAN'S NAME (Type) <i>H. H. BAYLUS</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7/11/58</i>	
22c. NAME OF CEMETERY OR CEMATORIUM <i>New Cathedral</i>		22d. LOCATION (City, State) <i>4300 Old Field Rd. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. L. Brown 901-3 Hollins St.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 10 '58</i>	
ADDRESS <i>1510 Annapolis 901-3 Hollins St.</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Brown</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 07714
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			c. LENGTH OF STAY IN lb life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			d. STREET ADDRESS Sherwood			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sherwood Rd.												
3. NAME OF DECEASED (Type or print) First Jane Middle Maulsby Last Pindell						4. DATE OF DEATH Month 7-26-58 Year 19						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-1873		9. AGE (In years (at birthday) 85 yrs.)		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) registered nurse			10b. KIND OF BUSINESS OR INDUSTRY hospital			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Adolphus Thomas Pindell						14. MOTHER'S MAIDEN NAME Jane Hall Yellott						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Address						
no			none			Thomas N. Pindell, Cockeysville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Melastatic Circumvallate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Circumvallate L. cct 73-627 10-2-58 DUE TO (c)												
INTERVAL BETWEEN ONSET AND DEATH 37 days												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) / (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> DATE SIGNED												
EXAMINER'S NAME (Type) Charles F. O'Donnell												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-58		22c. NAME OF CEMETERY OR CREMATORIAL Sherwood Episcopal		22d. LOCATION (City, town, or county) Cockeysville, Md. (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks</i>						ADDRESS 622 York Rd., Towson, Md.		24a REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7728

CERTIFICATE OF DEATH

Reg. Dist. No

07713
Na

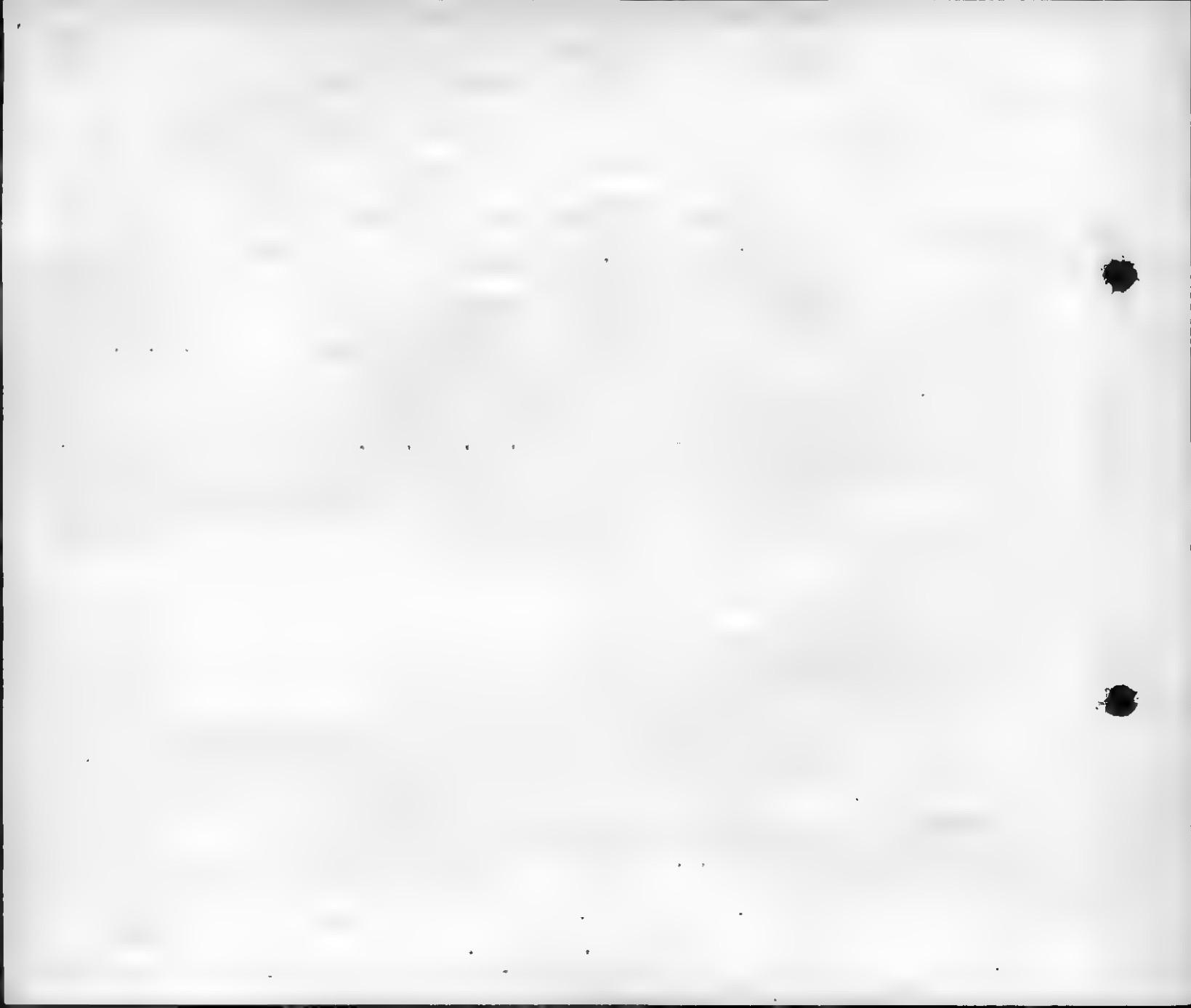
1. PLACE OF DEATH o COUNTY Baltimore				MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE New York b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 7 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 320 West 115th Street				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First WILLIE	Middle L.	Last PINKARD	4. DATE OF DEATH July 7 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1919	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Taxicab		11. BIRTHPLACE (State or foreign country) Notasulga, Alabama		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME John G. Pinkard				14. MOTHER'S MAIDEN NAME Lillie Rowell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 417-14-4390		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE BACTERIA MENINGITIS (AEROBACTER AEROGENES) INTERVAL BETWEEN ONSET AND DEATH FEW DAYS 3402 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) VA	(County)	(State)
21. I certify that attended the deceased from 8:15 AM 7/7/1958 to 3:15 PM 7/7 1958 and that death occurred at 3:15 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) CHIEN WEI LAN, M.D. M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 7/9/58								
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/14/1958		22c. NAME OF CEMETERY OR CREMATORIAL Shiloh Cemetery		22d. LOCATION (City, town, or county) Notasulga, Alabama		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arlyn S. Phillips</i>		ADDRESS 1808-10 N. Monroe St. Baltimore 17, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE <i>Al. E. C.</i>		

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours, after death.

VS A15 (4)
15M 10/57

SHIPPED TO: McKenzie Funeral Home, Tuskegee, Alabama



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7617 CERTIFICATE OF DEATH

07718

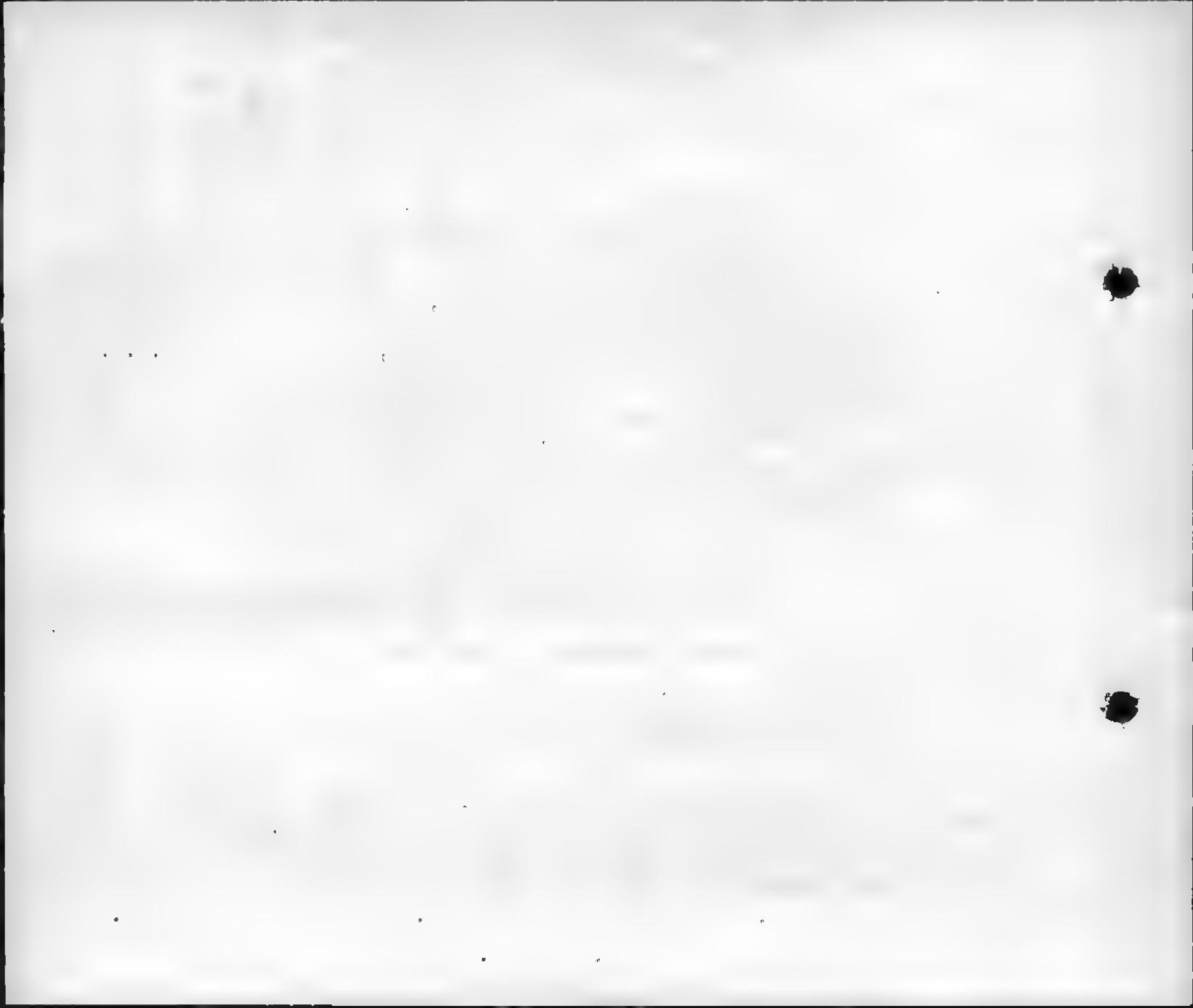
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for us to file in the burial-transit permit. Then please remove carbon papers.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK-TV		c. LENGTH OF STAY IN lb 57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8101 Cornwall Road		e. STREET ADDRESS 8101 Cornwall Road		f. DATE OF DEATH July 14 1958		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sophia		First	Middle	Last	Pitman	Month	Year
4. SEX Female		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH April 30, 1875	8. AGE (In years last birthday) 83 yrs	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Scranton, Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Keiper		14. MOTHER'S MAIDEN NAME Mary		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ralph Hosier		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Hire		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Scranton		(County) Scranton		(State) Penna.	
21. I certify that I attended the deceased from May 14 1958 to July 14 1958 , that I last saw the deceased alive on July 13 1958 , and the death occurred at 6800 Mornington . ACTUAL SIGNATURE M. B. Davis M.D.		ADDRESS (Street, city or town, state) Dundalk, MD 7/14/58		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 14, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Abington Hills Cem.		22d. LOCATION (City, town, or county) Scranton (State) Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul St.		24a. REC'D BY REGISTRAR DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE Reba Smith	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

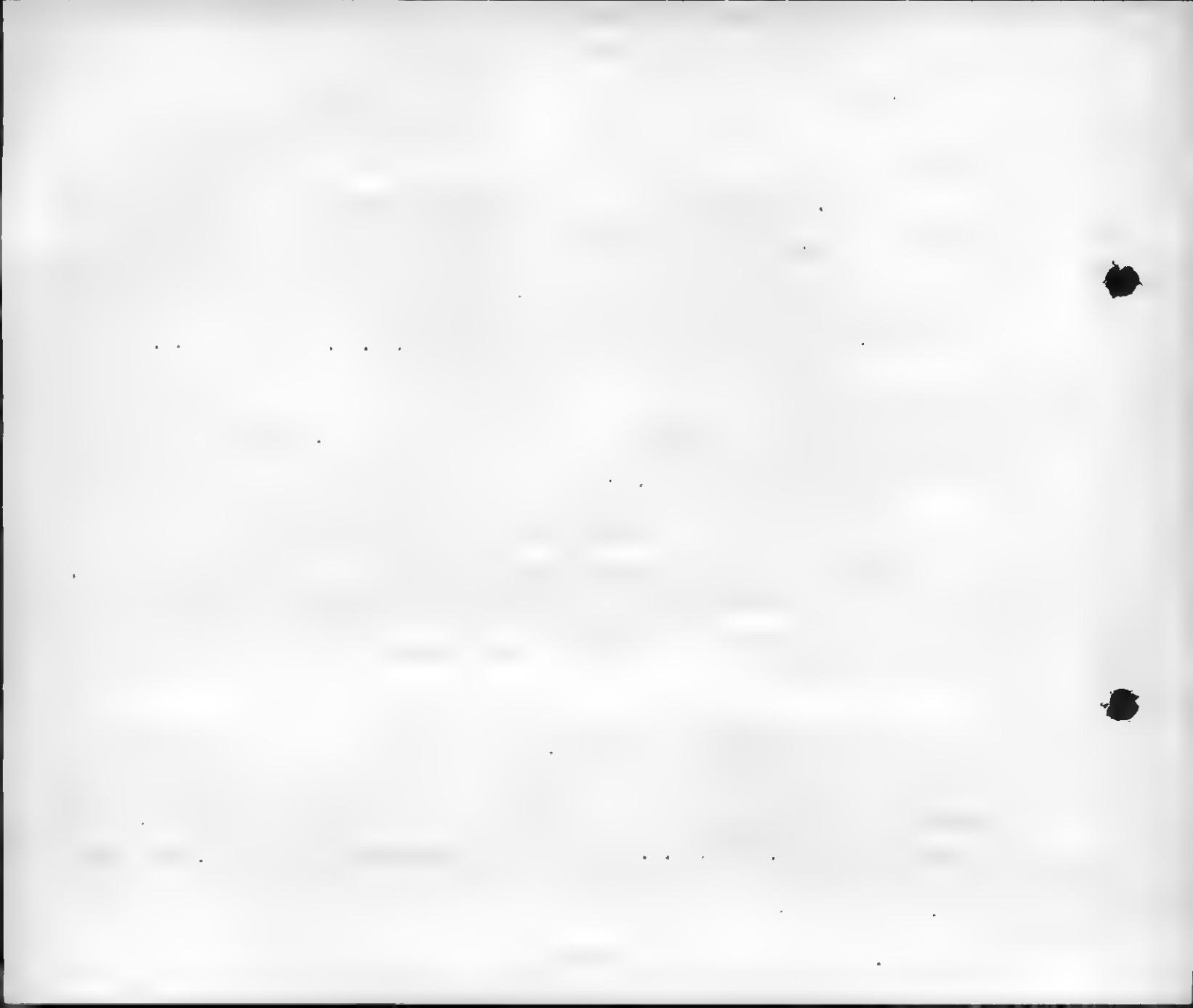
7618 CERTIFICATE OF DEATH

Reg. Dist. No. 07717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers from 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE South Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 1 mth 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 741 S. Avondale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Erskine	Middle Sylvester	Last Plummer
4. DATE OF DEATH	Month July	Day 17	Year 1958
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-1912
9. AGE (In years last birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker	10b. KIND OF BUSINESS OR INDUSTRY Goodyear Shoe Shop	11. BIRTHPLACE (State or foreign country) Abbeville, S. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charlie Plummer	14. MOTHER'S MAIDEN NAME Martha Burns		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	16. SOCIAL SECURITY NO 249-28-5024	17. INFORMANT Alice Durham - 717 S. Avondale Road	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Hypertensive Cardiovascular Disease	
(c)		DUE TO Cerebral Apoplexy	
5 years			
3 mons. 16 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7:30 P.M.
20f. (City or town) Greenville		(County) Greenville (State) South Carolina	
21. I certify that I attended the deceased from June 9, 1958 to July 17, 1958 , that I last saw the deceased alive on July 16, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 140 Oak Avenue, Dundalk 22, Maryland		DATE SIGNED July 17, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-58	22c. NAME OF CEMETERY OR CREMATORIUM Longbranch Baptist Church
22d. LOCATION (City, town, or county) Greenville, South Carolina		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	24a. REC'D BY REGISTRAR DATE JUL 18 '58
		24b. REGISTRAR'S SIGNATURE Albert	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07718

7729

CERTIFICATE OF DEATH

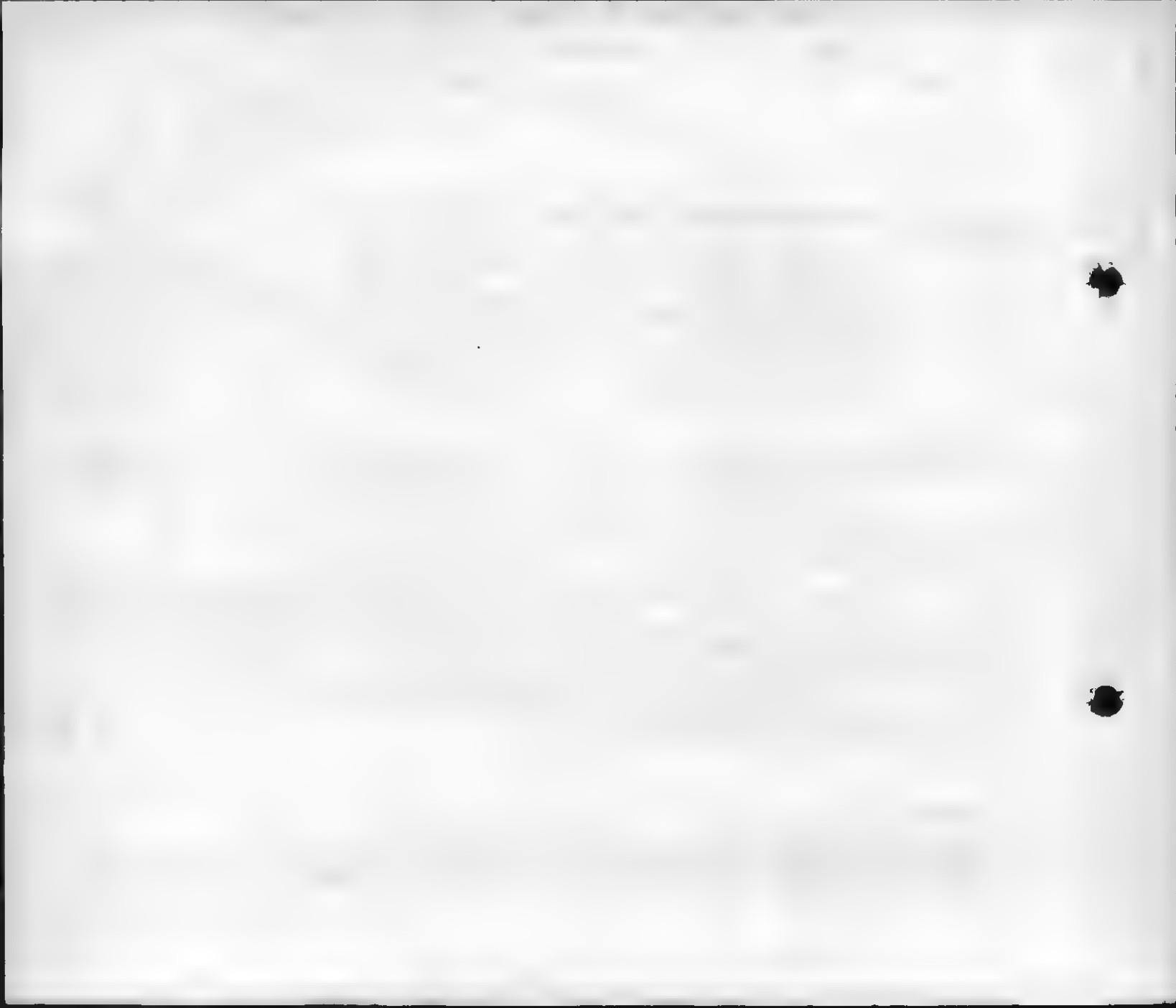
Reg. Dist. No.

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial permit. Then please remove carbon paper page 3 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #24		b. COUNTY BALTIMORE	
c. LENGTH OF STAY IN 1b #24		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 719 OLD NORTH POINT RD.		d. STREET ADDRESS 719 OLD NORTH POINT RD.	
3. NAME OF DECEASED (Type or print) ANTHONY		First J.	Middle RAAB
4. DATE OF DEATH JULY 16, 1958.		Last 72 yrs.	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 13, 1886
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CARPENTER	
11. BIRTHPLACE (State or foreign country) BALTIMORE Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE RAAB		14. MOTHER'S MAIDEN NAME LOUISE PAUL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT CATHERINE S. RAAB	
		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
CORONARY Thrombosis			
10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1958 to July 16, 1958 , that I last saw the deceased alive on July 16, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris A. Jacobs		ADDRESS (Street, city or town, state) 1010 North Point Rd. Balt 24 hr	
PHYSICIAN'S NAME (Type) Morris A. Jacobs		DATE SIGNED 7/18/58	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-19-58	
22c. NAME OF CEMETERY OR CREMATORIUM ST. JOSEPH'S CEMETERY		22d. LOCATION (City, town, or county) FULTERTON	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jailes		(State) MD.	
24a. ADDRESS 901 S. CONKLING ST. BALTO., MD.		24b. REC'D BY REGISTRAR Jul 18 '58	
		24c. REGISTRAR'S SIGNATURE W. E. Miller	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07719

7730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Towson</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		d. STREET ADDRESS <i>8340 Hillendale Road</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8340 Hillendale Road</i>				d. STREET ADDRESS <i>8340 Hillendale Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Mrs.</i>	Middle <i>Sadye</i>	Last <i>C.</i>	4. DATE OF DEATH <i>Reese</i>	Month <i>July</i>	Day <i>16,</i>	Year <i>1958</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 23, 1903</i>	9. AGE (In years from last birthday) <i>yrs.</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS <i>Days</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>Samuel R. Harten</i>		14. MOTHER'S MAIDEN NAME <i>Florence Mc Dowell</i>				Address <i>same</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Charles E. Reese,</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Dilatation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO <i>Hypostatic Pneumonia</i> <i>General Carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore, Maryland</i>	(County) <i>Baltimore County</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from alive on <i>July 16, 1958</i> , to <i>July 16, 1958</i> , that I last saw the deceased and that death occurred at <i>7:15 AM</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Dr Lee K. Farago</i>		ADDRESS (Street, city or town, state) <i>M.D. 8255 Loch Raven Blvd, Towson</i>		DATE SIGNED <i>7/16/58</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/19/1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Gardens of Faith</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State) <i>Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road \$ 14</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUL 17 '58</i>		24b. REC'D BY REGISTRAR DATE <i>Jul 17 '58</i>		24c. REC'D BY REGISTRAR DATE <i>Jul 17 '58</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with Note 3 should be detached for the burial-transit permit. Then, please remove carbon papers. Notes 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G2 L-12-1954

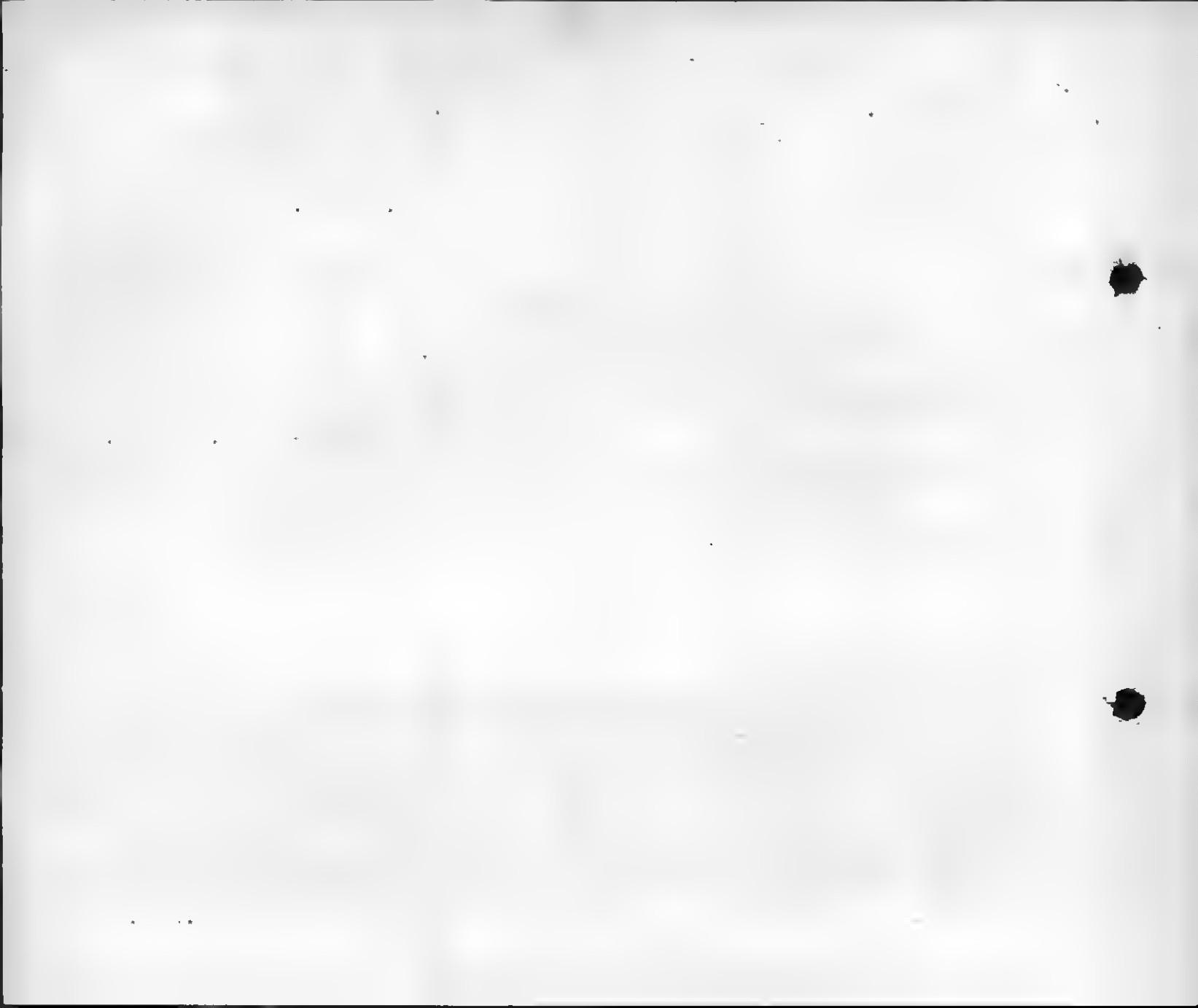
07720

7731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eldersburg (En route)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Being transferred to a home in Sykesville				d. STREET ADDRESS 403 E. 22nd St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First HATTIE	Middle	Last REMINGTON	4. DATE OF DEATH July 7, 1958	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1875	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendance Officer		10b. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Jessie Remington		14. MOTHER'S MAIDEN NAME Mary Catherine Wagner		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Harriet Remington - 403 E. 22nd St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Anterior dilatation DUE TO } (c) Myocarditis		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days Year Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1958, to <u>July 7, 1958</u> , that I last saw the deceased alive on <u>July 7, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above				ADDRESS (Street, city or town, state) 2824 St Paul St Baltimore 18, Md.	
ACTUAL SIGNATURE <i>Herbert M. Foster</i>				DATE SIGNED 1958	
PHYSICIAN'S NAME (Type) HERBERT M. FOSTER					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Nickens & Sons - Balto, Md.</i>		ADDRESS 17		24a. REC'D BY REGISTRAR DATE 1958	
				24b. REGISTRAR'S SIGNATURE <i>John J. Nickens & Sons - Balto, Md.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

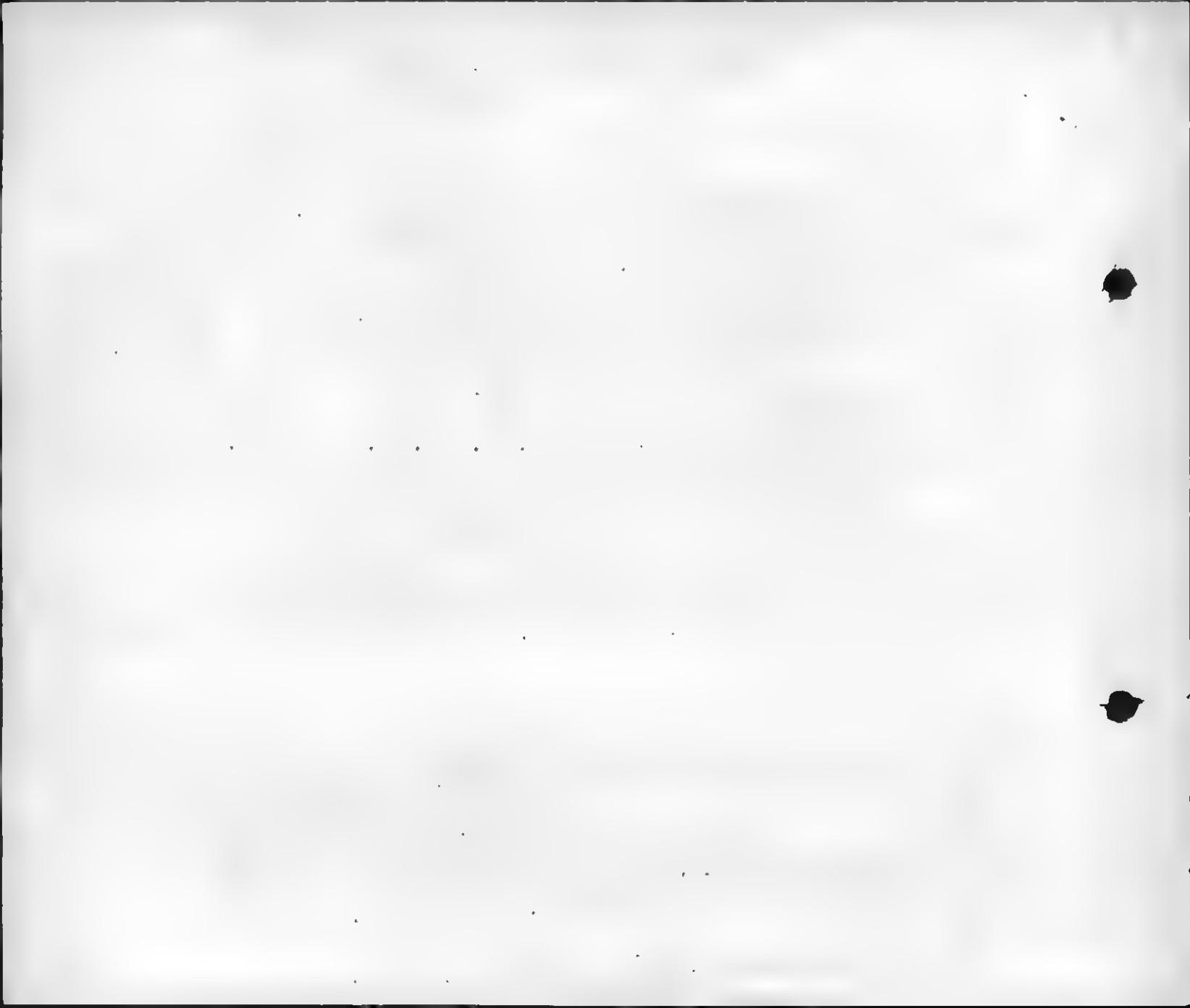
7732 CERTIFICATE OF DEATH

07721

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office.
 page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper.
 The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 101 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1103 Belvieu Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES		First A.	Middle RENNIE	Last RENNIE	4. DATE OF DEATH July 7 1958	Month July	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1877	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Can Company		11. BIRTHPLACE (State or foreign country) Edinburgh, Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Archibald Rennie		14. MOTHER'S MAIDEN NAME Isabel Acton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 215-05-5456		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO CEREBRAL ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)						UNKNOWN		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bleeding Duodenal Ulcers- Duration 4 Days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, Fort Howard, Maryland		20f. (City or town) VAH	(County) Fort Howard	(State) Maryland
21. I certify that I attended the deceased from March 28, 1958 , to July 7, 1958 , and that death occurred at 110P.M. from the causes and on the date stated above ACTUAL SIGNATURE <i>Chien Wei Lan</i>						ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland		
						DATE SIGNED 7/8/58		
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		22b. DATE THEREOF 7/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Tickner & Sons, North & Penna. Maryland</i>		ADDRESS Aves.		24a. REC'D BY REGISTRAR VAH		24b. REGISTRAR'S SIGNATURE VAH		



17722

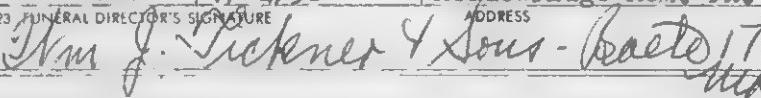
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

7733

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Farm PHA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN fb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8300 Block Pulaski Highway		d. STREET ADDRESS 1315 N. Milton Avenue	
e. NAME OF DECEASED (Type or print) EARL C. RIIDIGER		f. DATE OF DEATH Lost RIIDIGER, Jr. Month July Day 18 Year 1958	
g. SEX Male h. COLOR OR RACE White i. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> j. DATE OF BIRTH Dec. 16, 1924		k. AGE (in years from birthday) 84 33 l. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS	
l. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Tech.		l. 10b. KIND OF BUSINESS OR INDUSTRY Industrial Medicine	
l. 13. FATHER'S NAME Earl C. Riidiger		l. 14. MOTHER'S MAIDEN NAME Edith Lottes	
l. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No		l. 16. SOCIAL SECURITY NO 16. SOCIAL SECURITY NO	
		l. 17. INFORMANT Mrs. Margaret Riidiger - 1315 N. Milton Ave.	
		l. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Gunshot Wound of Chest.	
		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 481X	
		DUE TO (c)	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot in chest.	
20c. TIME OF INJURY Month, Day, Year Hour o. m 7/18 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Baltimore	
(County) Md.		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		DATE SIGNED 7/19/58	
EXAMINER'S NAME (Type) William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/58	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 		24a. REC'D BY REGISTRAR DATE JUL 21 '58	
		24b. REGISTRAR'S SIGNATURE 	
VS. ATSM SM 2/57			



MARYLAND STATE DEPARTMENT OF HEALTH

07723

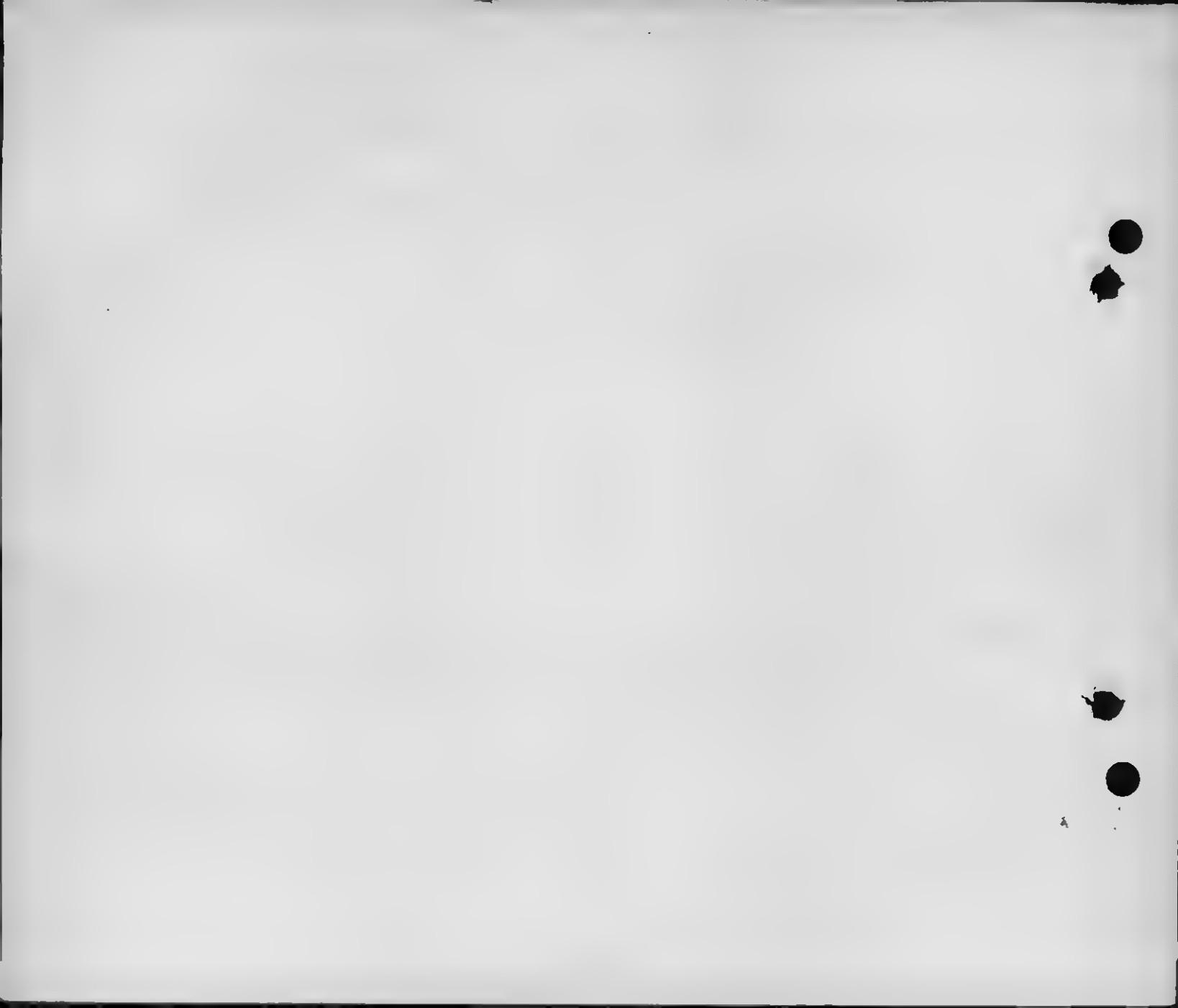
CERTIFICATE OF DEATH
7734 FOR MEDICAL EXAMINERS

Reg. Dist. No.

MARGIN RESERVED FOR BOUNDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>BALTIMORE Co.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PHOENIX (RURAL)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Phoenix (RURAL)</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DANCE MILL RD</u>		STREET ADDRESS <u>DANCE MILL RD</u>		
3. NAME OF DECEASED (Type or Print)	(First) <u>JOSEPH</u>	(Middle) <u>FRANCIS</u>	(Last) <u>RILEY JR.</u>	
4. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>27 JULY 1953</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Francis Riley, Sr.</u>	14. MOTHER'S MAIDEN NAME <u>MAYME Elizabeth Bittner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT AND ADDRESS <u>Ruth Etta Bittner (MATERNAL Grandmother)</u>	18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs.</u>	
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>Immediate cause <u>(a) MASSIVE CAVITONITRAL Hemorrhage</u> <u>Antecedent cause(s) (b) APLASTIC Anemia - etiology unknown.</u> <small>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last</small></p> <p>(c) <u>—</u></p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p> <p>19a. DATE OF OPERATION <u>—</u> 19b. MAJOR FINDINGS OF OPERATION <u>—</u></p> <p>20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>				
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>—</u>	PLACE (Name, farm, factory, street, of office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	(STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> m. <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>		
<p>22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/></p> <p>SIGNATURE <u>J. H. G. Carlson</u> (Degree or title) <u>M.D.</u> ADDRESS <u>Phoenix P.O. Md.</u> DATE SIGNED <u>7/6/58.</u></p> <p>23. INDUSTRIAL CREMATION REMOVAL (Specify) <u>—</u> DATE THEREOF <u>7-9-58.</u> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <u>HYDE - MD</u> (State) <u>—</u></p> <p>DATE REG'D BY LOCAL REG. <u>—</u> REGISTRAR'S SIGNATURE <u>—</u> 24. FUNERAL DIRECTOR <u>W.M COOK-TOWSON, INC - TOWSON - MD.</u> ADDRESS <u>—</u></p>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7735 CERTIFICATE OF DEATH

Reg. Dist. #7724

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	c. LENGTH OF STAY IN lb 1 Day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 256 S. Loudon Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 819 South Ridge Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Elizabeth A. Roberts	First Elizabeth	Middle A.	Last Roberts		
4. DATE OF DEATH July 6, 1958	Month July	Day 6	Year 1958		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1893		
9. AGE (In years lost birthday) 65 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME DANIEL SMALLACOMBE	14. MOTHER'S MAIDEN NAME ELIZABETH MAYOR	Address 256 S. Loudon Ave.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Brinley Parker	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. July 6, 1958	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4804 Frederick Ave	20f. (City or town) Chinchilla	(County) Pennsylvania	(State)
21. I certify that I attended the deceased from July 6, 1958 to July 6, 1958 , that I last saw the deceased alive on July 6, 1958 , and that death occurred at 1 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert W. Japp M.D.	ADDRESS (Street, city or town, state) 4804 Frederick Ave	DATE SIGNED 7/6/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Shady Lane Cem.	22d. LOCATION (City, town, or county) Chinchilla	(State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schuh	ADDRESS BALTO. Md.	24a. REC'D BY REGISTRAR DATE JUL 9 '58	24b. REGISTRAR'S SIGNATURE Alt. eden		

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7736 CERTIFICATE OF DEATH

17725-

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>BALTC.</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o STATE <i>MARYLAND</i>	b COUNTY <i>BALTC.</i>			
3. LENGTH OF STAY IN 1b <i>ESSEX</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>343 SASSAFRAS RD.</i>	5. FIRST MIDDLE LAST <i>SARAH E ROBINSON</i>	6. DATE OF DEATH <i>JULY 18, 1897</i>	7. MONTH DAY YEAR <i>JULY 22 1958</i>			
8. SEX <i>FEMALE</i>	9. COLOR OR RACE <i>WHITE</i>	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH <i>JULY 18, 1897</i>	12. AGE (In years last birthday) <i>61 yrs.</i>	13. IF UNDER 1 YEAR Months Days Hours Min. <i>0 months 0 days 0 hours 0 min.</i>	14. IF UNDER 24 HRS. Months Days Hours Min. <i>0 months 0 days 0 hours 0 min.</i>
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	16. KIND OF BUSINESS OR INDUSTRY <i></i>	17. BIRTHPLACE (State or foreign country) <i>OHIO</i>	18. CITIZEN OF WHAT COUNTRY <i></i>			
19. FATHER'S NAME <i>JOHN Mc GIN</i>	20. MOTHER'S MAIDEN NAME <i>LILLIAN MARSH</i>	21. ADDRESS <i></i>	22. INTERVAL BETWEEN ONSET AND DEATH <i>7 minutes</i>			
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1445X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Ate pulmonary & cerebral heart failure</i>				24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	25. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. MEDICAL CERTIFICATION 26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	26b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 26c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19	26d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	26e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26f. (City or town) (County) (State) <i>7736 MARYLAND</i>	26g. ADDRESS (Street, city or town, state) <i>424 Eastern Ave</i>	26h. DATE SIGNED <i>7/24/58</i>	
27. I certify that I attended the deceased from _____, <i>June</i> , 19 <i>54</i> , to <i>7/22, 1958</i> , that I last saw the deceased alive on <i>7/21, 1958</i> , and that death occurred at <i>7736 MARYLAND</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Platt</i>	28. PHYSICIAN'S NAME (Type) <i>J. PLATT, M.D.</i>	29. BURIAL, CREMATON, REMOVAL (Specify) <i>BURIAL</i>	30. DATE THEREOF <i>JULY 24, 1958</i>	31. NAME OF CEMETERY OR CREMATORIAL <i>HOLY LANDS</i>	32. LOCATION (City, town, or county) <i>BALTC. CO. MARYLAND</i>	
33. FUNERAL DIRECTOR'S SIGNATURE <i>Felic G. Lonna</i>	34. ADDRESS <i>418 Eastern Blvd</i>	35. REC'D BY REGISTRAR DATE <i>JUL 25 '58</i>	36. REGISTRAR'S SIGNATURE <i>Alv. Lee</i>			



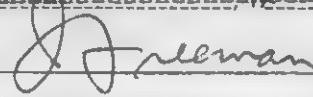
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7737 CERTIFICATE OF DEATH

Reg. Dist. No.

07726

HOSPITAL OR ATTENING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 28 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		d. STREET ADDRESS Box 324 Liberty Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	(Served as First Elbert (NMI) Middle D. ELBERT)		Robosson (ROBOSSON)	4. DATE OF DEATH July 2 1958	Month July	Day 2	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1877	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer- Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) North Branch, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Elijah Robosson				14. MOTHER'S MAIDEN NAME Rebecca De Vires				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) Yes		16. SOCIAL SECURITY NO. SAW		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO ARTERIOSCLEROTIC HEART DISEASE (c) DUE TO UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture, neck, Right femur. Operation-Closed reduction fracture neck right femur- 6/18/58								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 904.9						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 4, 1958 , to July 2, 1958 , when I last saw the deceased XXXXXX, VA, XXXXX , and that death occurred at VAH, Fort Howard, Maryland , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 7/2/58								
ACTUAL SIGNATURE  M.D. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical Service VAH, FORT HOWARD, MARYLAND								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-5-58	22c. NAME OF CEMETERY OR CREMATORIUM Wards Chapel Cemetery		22d. LOCATION (City, town, or county) Liberty Rd., Baltimore Co., Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers Funeral Home			ADDRESS 5005 Park Heights Ave.	24a. REC'D BY REGISTRAR JUL 8 '58	24b. REGISTRAR'S SIGNATURE Albert E. Loring			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7738

CERTIFICATE OF DEATH

07727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore		a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Newk 502 Forest Lane		e. STREET ADDRESS 502 Forest Lane	
3. NAME OF DECEASED (Type or print) Elizabeth		First Middle Last	4. DATE OF DEATH July 28, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Gunn		14. MOTHER'S MAIDEN NAME Sarah Mac Naugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lawrence Littman		Address 502 Forest Lane Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Artriosclerotic C V Dis.		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Artriosclerotic C V Dis. (c) DUE TO Gout & Liver Malfunction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Pneumonia congestive		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1958, to July 28, 1958, that I last saw the deceased alive on July 28, 1958, and that death occurred at 1 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles E. Carr, Jr., M.D., 6201 York Road, Baltimore, Md. DATE SIGNED Actual Signature: Charles E. Carr, Jr., M.D., 6201 York Road, Baltimore, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 26, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Cathedral Cemetery		22d. LOCATION (City, town, or county) Bellevue Township 11.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Baltt.-Md.		24a. REC'D BY REGISTRAR DATE JUL 29 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE A. Leach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

107728

7739 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towsonville</i>	c. LENGTH OF STAY IN 1b <i>12 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	b. COUNTY <i>Baltimore</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10 Hawthorne</i>	d. STREET ADDRESS <i>10 Hawthorne Rd</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Thelma Elaine Rohde</i>	First	Middle	Last
4. DATE OF DEATH <i>July 4 1958</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 13, 1911</i>
9. AGE (In years last birthday) <i>47 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>William L Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Mary Criswell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212 22 3219</i>	
17. INFORMANT <i>Robert Rohde</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
		INTERVAL BETWEEN ONSET AND DEATH <i>9 mos.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Pikesville</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Oct 1957</i> to <i>4 July 1958</i> that I last saw the deceased alive on <i>4 July 1958</i> , and that death occurred at <i>6:40 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H Royse</i>		ADDRESS (Street, city or town, state) <i>808 Reservoir Rd</i> DATE SIGNED <i>4 July 58</i>	
PHYSICIAN'S NAME (Type) <i>Paul H Royse</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-8-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Dreid Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Neurell Pikesville, Md.</i>		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alvin Leach</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7740 CERTIFICATE OF DEATH

Reg. Dist. No.

07729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Held in by the funeral director, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Calif. b. COUNTY Los Angeles	
stevenson		6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Villa Poco Valley Rel-		439 16th St.		July 5 1958	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Romano			Romani	July 5	1958
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 28, 1883	9. AGE (In years last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Livorno - Italy	
Musician				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Romano		14. MOTHER'S MAIDEN NAME Elvira Sidemagnati		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 553-14-4783		17. INFORMANT (Son) Nino Berman, - Santa Monica Calif.	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1		DUE TO Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) AS.C.V.D.		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 18. WAS AUTOPSY PERFORMED? None YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1958, to July 5, 1958, that I last saw the deceased alive on July 4, 1958, and that death occurred at 1:10 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Edgar F. Berman		M.D.		ADDRESS (Street, city or town, state) 701 Cathedral St. Baltimore, Md. DATE SIGNED July 5, 1958	
PHYSICIAN'S NAME (Type) Edgar F. Berman					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-58		22c. NAME OF CEMETERY OR CREMATORIUM Laurel Ridge	
22d. LOCATION (City, town, or county) Pikesville, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Neerell		ADDRESS Pikesville, Md.		24a. REC'D BY REGISTRAR DATE JUL 9 1958	
				24b. REGISTRAR'S SIGNATURE Abner	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7741 CERTIFICATE OF DEATH

Reg. Dist. No. 07730

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7		d. STREET ADDRESS Old Court Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Court Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARTHA F. ROSENBERGER		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 3-15-1884	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Lansdale, Pa.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Fuss		14. MOTHER'S MAIDEN NAME Susan ?		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Grace Hawes, Baltimore 7, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>Cerebral Dumb - Malaria</i> (c) <i>Pneumonia & Jaundice</i>						INTERVAL BETWEEN ONSET AND DEATH 2 hrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ellicott City		(County) Md. (State)
21. I certify that I attended the deceased from March 12, 1958 , to July 17, 1958 , that I last saw the deceased alive on July 17, 1958 , and that death occurred at Ellicott City , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 620 East Belvoir St.		
ACTUAL D. E. Norton						DATE SIGNED July 21, 1958		
PHYSICIAN'S NAME (Type) F. E. W. Roos.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-21-58		22c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.		ADDRESS		24a. REC'D BY REGISTRAR Alv. Schreier		24b. REGISTRAR'S SIGNATURE Alv. Schreier		
				DATE JUL 21 '58				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07731

7742 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>			c. LENGTH OF STAY IN 1b <i>ESSEX</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>307 South Eastern Terrace</i>			d. STREET ADDRESS <i>307 South Eastern Terrace</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Gretchen S</i>	Middle <i>Rudel</i>	Last <i></i>	4. DATE OF DEATH Month <i>July</i> Day <i>9</i> Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 12, 1901</i>	9. AGE (In years lost birthday) <i>56 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Hayes Cooper</i>			14. MOTHER'S MAIDEN NAME <i>Zernie Bennett</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>none</i> 17. INFORMANT <i>Mr. Wm. Rush - 723 Stamford Rd. #29</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AURICULAR FIBRILLATION</i> DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i> (State) <i></i>
21. I certify that I attended the deceased from <i>FEB 24, 1958</i> to <i>JULY 9, 1958</i> , that I last saw the deceased alive on <i>MAY 7, 1958</i> , and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Joseph Miceli</i>			ADDRESS (Street, city or town, state) <i>108 S. TAYLOR HT</i> DATE SIGNED <i>7/9/58</i>		
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 12, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodlawn</i>	22d. LOCATION (City, town, or county) <i>Woodlawn</i> (State) <i>7 Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J Stansbury - 6411 Windsor Mill Rd.</i>			ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>JUL 11 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alv. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbons papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

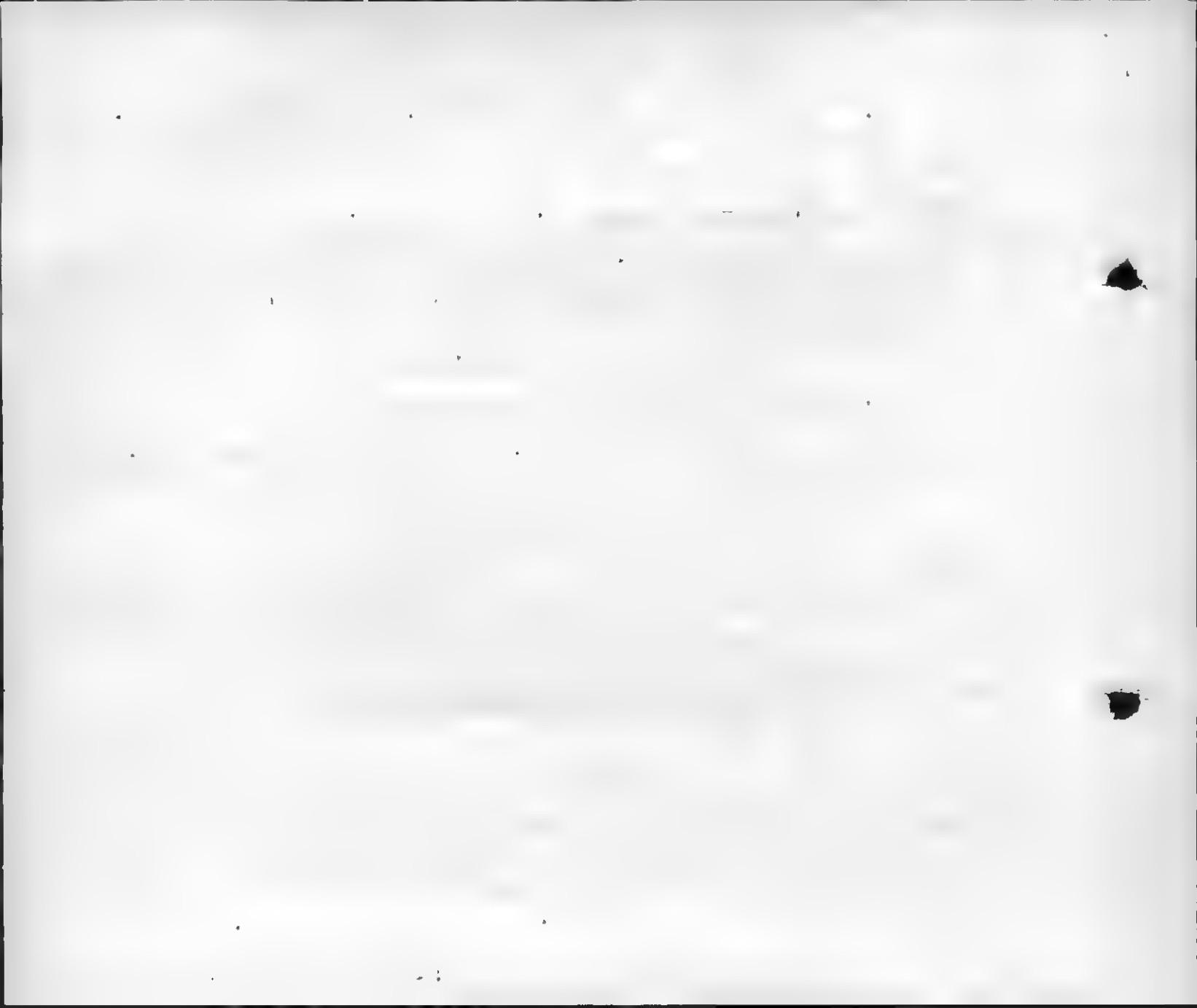
7743

CERTIFICATE OF DEATH

07732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			b. COUNTY Balto.		
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nurs. Home-1002 Rolling Rd.			d. STREET ADDRESS 7126 Dogwood Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JOHN	Middle H.	Last RUSSELL	4. DATE OF DEATH Month July	Day 21 , Year 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1871	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Md.		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William W. Russell			14. MOTHER'S MAIDEN NAME Jane Reed		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Frances Henry - 7126 Dogwood Rd.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO ARTERIO SELEZIO CARDIO VASCULAR DISEASE					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CREMATA PROSTATIS HYPERPLASIA (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 58 , to 7/21 , 19 58 , that I last saw the deceased alive on 7/21 , 19 58 , and that death occurred at 9 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE John W. Russell M.D. 5811 Edmonson Ave. 7/21/58					
DATE SIGNED					
PHYSICIAN'S NAME (Type)		John W. Russell M.D. 5811 Edmonson Ave. 7/21/58			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cem.	
22d. LOCATION (City, town, or county) Woodlawn, Md.					
(State)					
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS Wm. J. Fischer & Sons, Baileys Hill					
24a. REC'D BY REGISTRAR DATE JUL 23 '58					
24b. REGISTRAR'S SIGNATURE John W. Russell					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
page 3 should be detached for use of the burial permit. Then please remove carbon paper.
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07733

7744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Conv. Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. STREET ADDRESS 1938 Jasmine Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catherine Elizabeth Ruth		First Catherine	Middle Elizabeth	Last Ruth	4. DATE OF DEATH Month July Day 24 Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 18, 1879	9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John F. Moore		14. MOTHER'S MAIDEN NAME Mary C. Bornemann		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-20-7510		17. INFORMANT Address Mr. Walter Ruth 1938 Jasmine Road 22	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Carcinoma of Uterus</i>			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)			
DUE TO					
(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Senility</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 21, 1958</i> to <i>July 24, 1958</i> , that I last saw the deceased alive on <i>July 21, 1958</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>4508 Edmondson Village</i> DATE SIGNED <i>2/26/58</i>			
ACTUAL SIGNATURE <i>D. C. Mc Loughlin</i>		M.D. <i>4508 Edmondson Village</i> DATE SIGNED <i>2/26/58</i>			
PHYSICIAN'S NAME (Type) D. C. Mc Loughlin M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel	
22d. LOCATION (City, town, or county) O'Donnell St. Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alt. Search</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7745 CERTIFICATE OF DEATH

17734

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use. The burial-transit permit, Then please remove carbon papers, page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4301 Belmar Ave (6)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4301 Belmar Ave (6)		d. STREET ADDRESS 4301 Belmar Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First ALBERT Middle Schaut Last Lost				4. DATE OF DEATH July Month 3 Day 14 Year 1958			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Otto		14. MOTHER'S MAIDEN NAME Elizabeth Gerber Schaut					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 317-22-6710		17. INFORMANT Estebil Albert Schaut, Baltimore, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Heart attack (dropped dead)		INTERVAL BETWEEN ONSET AND DEATH immediate			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) Sudden death					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore	
21. I certify that I attended the deceased from _____		1958, to _____		1958, that I last saw the deceased alive on _____, and that death occurred at 6:00 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DR. John GELDRIICH M.D. 2703 W. Belvedere Ave	
ACTUAL SIGNATURE DR. John GELDRIICH						DATE SIGNED 7-5-58	
PHYSICIAN'S NAME (Type) Dr John Geldrich							
22a. BURIAL, Cremation, or other (Specify) Burial		22b. DATE THEREOF 7/7/58		22c. NAME OF CEMETERY OR CREMATORIAL Gordon Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Wolverton Funeral Home Inc		ADDRESS 6306 - Belair Rd, Baltimore - 6, Md		24a. REC'D BY REGISTRAR DATE JUL 10 '58		24b. REGISTRAR'S SIGNATURE Carl B. Wolverton	

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital ending physician.
TO FUNERAL DIRECTOR: After this page has been signed by the attending physician and completed in by the funeral director, page 3 should be detached from this page and given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

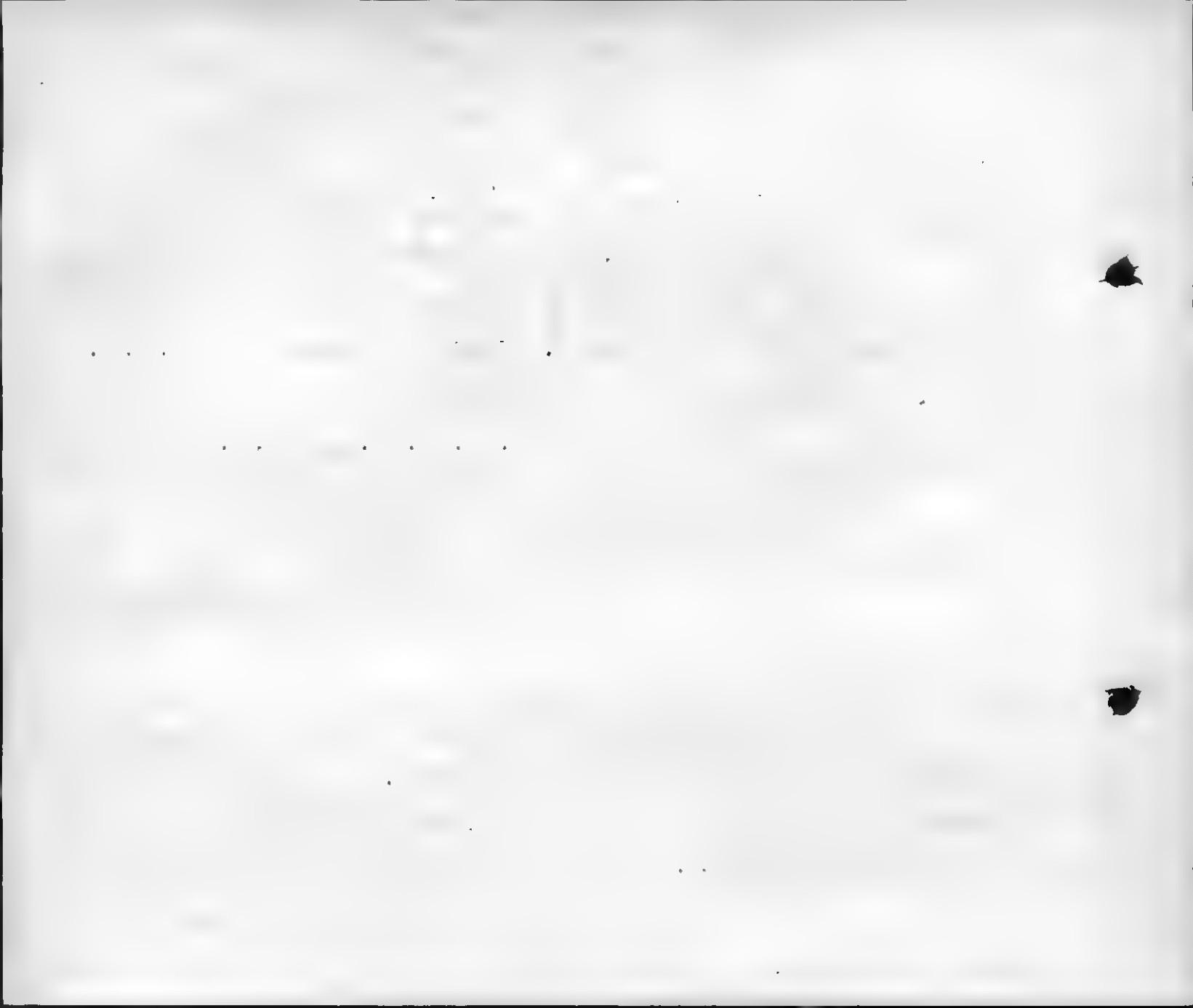
7746

CERTIFICATE OF DEATH

07735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 20 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. INSTITUTION		g. STREET ADDRESS 1908 Wilkins Avenue	
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle P.
4. DATE OF DEATH Month July		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH September 18, 1901	
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months 0	
11. IF UNDER 24 HRS Days 0		12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Marshall		10b. KIND OF BUSINESS OR INDUSTRY Cork & Seal Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Scheidegger		14. MOTHER'S MAIDEN NAME Katie Herman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown, list yes, give war or date of service) Yes W W I		16. SOCIAL SECURITY NO 212-28-6326	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BLEEDING, GASTROINTESTINAL TRACT AND HEPATORENAL INSUFFICIENCY DUE TO CIRRHOSIS OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS + UNKNOWN			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended the deceased from July 1, 1958 , to July 21, 1958 , and that death occurred at 7:35A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) M.D. CHIEN WEI LAN, FORT HOWARD, MARYLAND DATE SIGNED 7/21/58			
ACTUAL SIGNATURE <i>Chi Wei Lan</i>		PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 24 July 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Walters</i>		ADDRESS Pratt and Stricker Sts.	
Walters Funeral Home,		24a. REC'D BY REGISTRAR DATE JUL 22 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alv. edrich</i>	



FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Reg. Dist. No. 17736

If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page
4 should be forwarded to the Medical Examiner's Office along with form P.M. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowleys Quarters</i>	c. LENGTH OF STAY IN 16 <i>211 Bay Drive</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS <i>2863 Mayfield Avenue</i>	e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mr. August J.</i>	First <i>Schoenlein</i>	Middle <i>July 17th</i>	4. DATE OF DEATH <i>Dec. 25, 1883</i>	Month <i>19 58</i>	Day <i>19</i>	Year <i>58</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>74 yrs</i>	9. AGE (in years last birthday) <i>74 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>					
13. FATHER'S NAME <i>Lorenz Schoenlein</i>		14. MOTHER'S MAIDEN NAME <i>?</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) <i>1120.1</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mary J. Schoenlein,</i>		Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>		DUE TO <i>PSCU Disease</i>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		DUE TO <i>(c)</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Injury</i>		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore, Maryland</i>		(County) <i>Maryland</i>	(State) <i>Maryland</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>M.B.Davis</i>		EXAMINER'S NAME (Type) <i>M.B. Davis M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <i>7/18/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/21/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>		ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>21</i>		24b. REGISTRAR'S SIGNATURE <i>Q31 class 1</i>			
VS. A15ME 5M 2/57									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07737

7625 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Relay					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5130 Rolling Road		d. STREET ADDRESS 5130 Rolling Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Herman		First H.	Middle H.	Last Schriner	4. DATE OF DEATH July 19, 1958	Month July	Day 19	Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1871		9. AGE (In years from birthday) 86 yrs	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired messenger		10b. KIND OF BUSINESS OR INDUSTRY Railway Express Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME Albert Schriner		14. MOTHER'S MAIDEN NAME Louisa M. Stell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Stella G. Ivey		Address 6130 Rolling Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 "DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) ✓		Valvular heart disease - c. decompen				INTERVAL BETWEEN ONSET AND DEATH ? many years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> or work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) J. 1958		(County) J. 1958	(State) J. 1958
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above ACTUAL SIGNATURE Frederick S. Beitler						ADDRESS (Street, city or town, state) 1047 Francis St. - Bella 27-168		DATE SIGNED 1958	
PHYSICIAN'S NAME (Type) Frederick S. Beitler									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Brooklyn, A.A.C.O.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Pl.		24a. REC'D BY REGISTRAR DATE JUL 21 '58		24b. REGISTRAR'S SIGNATURE Clifford J. Mitchell			

الآن نحن في

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07738.							
7748 CERTIFICATE OF DEATH										Reg. Dist. No.							
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks					c. LENGTH OF STAY IN 1b At home					b. COUNTY Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
f. STREET ADDRESS Sparks Road																	
3. NAME OF DECEASED (Type or print) Sarah					First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
					Emily	SCOTT		7	30	19	58						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-15-66		9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		12. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Hugh Scott					14. MOTHER'S MAIDEN NAME Mary Jane Mc Clure												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO No		17. INFORMANT R. Carleton Sharretts, Sparks Rd. Sparks Md.		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 192X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					<i>Malignancy Liver. Hyperplasia Hypertrophy. Cirrhosis</i>					INTERVAL BETWEEN ONSET AND DEATH. 3 months Greatest "							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Melanoma left eye - cataract Eye removed Jan '58										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County)		(State)							
21. I certify that I attended the deceased from July 30 , 19 58 to July 30 , 19 58 that I last saw the deceased alive on July 30 , 19 58 , and that death occurred at OP M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 1403 Park Ave. Baltimore, Md.		DATE SIGNED 7-31-58					
ACTUAL SIGNATURE <i>W.H. Woody</i>		PHYSICIAN'S NAME (Type) W.H. Woody															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-58		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Towson, Inc. 1050 York Rd.										ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

19. " - 21. 3-10. 2-11.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7749

CERTIFICATE OF DEATH

07739

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>133 Slade Ave</i>		e. STREET ADDRESS <i>6808 Westridge Rd</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sonia Boris Seidman</i>		First <i>Sonia</i>	Middle <i>Boris</i>
		Last <i>Seidman</i>	4. DATE OF DEATH 7-31-1958
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>6-20-1928</i>		9. AGE (In years last birthday) <i>30 yrs.</i>	10. IF UNDER 1 YEAR Months <i>30</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Potter</i>		14. MOTHER'S MAIDEN NAME <i>Sadie Abramson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Gilbert Seidman - same</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>Dysplastic Carcinoma of breast</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>1955</i> , to <i>7/30</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7/30</i> , 19 <i>58</i> , and that death occurred at <i>12-77</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leonard H. Golombich</i> ADDRESS (Street, city or town, state) <i>M.D. 7013 Liberty Rd. 7</i> DATE SIGNED <i>7/31/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-1-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Beth Tfiloh</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		24a. REC'D BY REGISTRAR DATE AUG 1 '58	
ADDRESS <i>2100 Eutaw Place</i>		24b. REGISTRAR'S SIGNATURE <i>Albert couch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

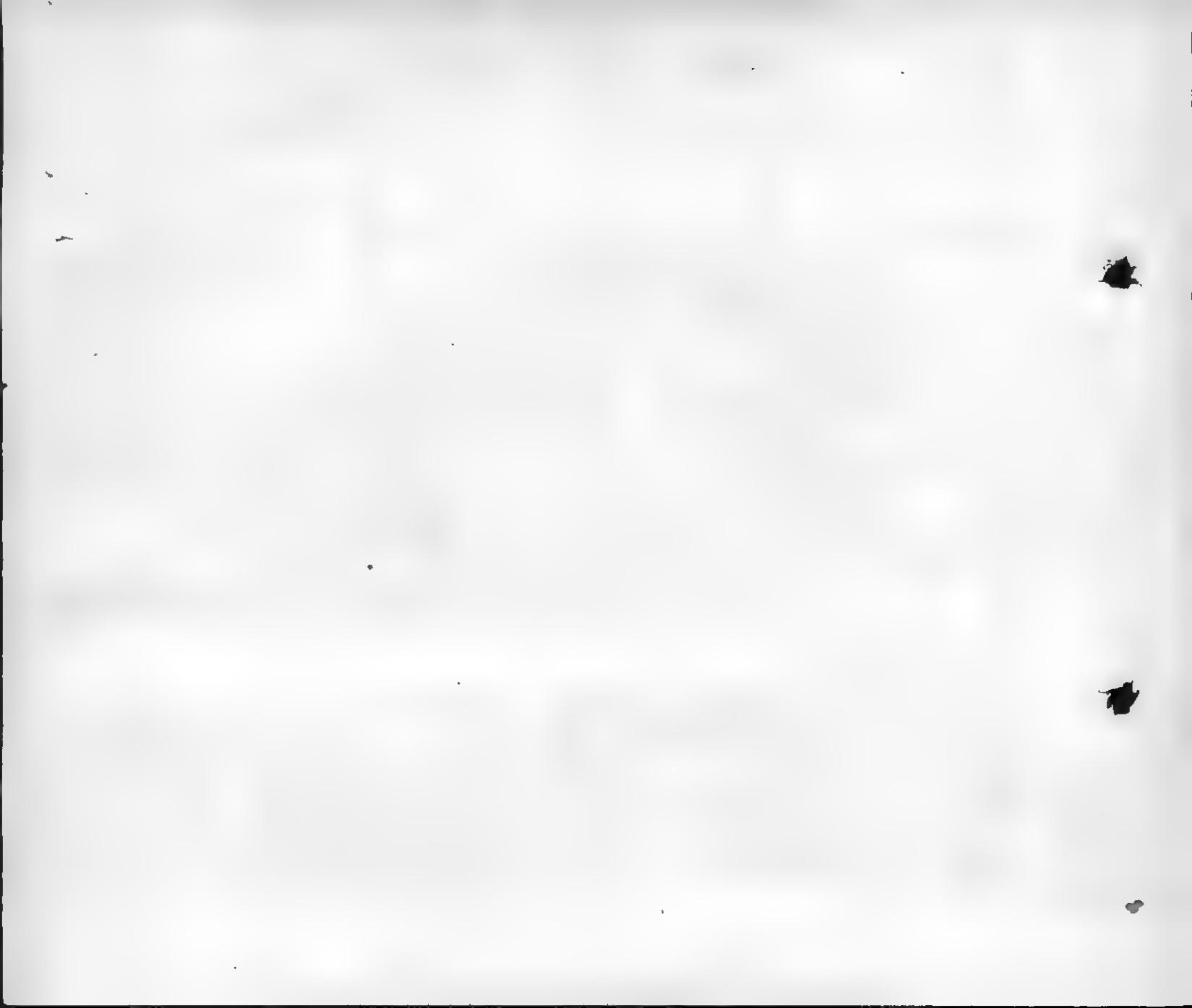
CERTIFICATE OF DEATH

07740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b .		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8027 Philadelphia Road		d. STREET ADDRESS 8027 Philadelphia Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs. Louisa	First	Middle	Last	4. DATE OF DEATH Seling	Month July	Day 11th	Year 1956
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1857	9. AGE (In years last birthday) 100 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Kummel		14. MOTHER'S MAIDEN NAME Magdalena Abels					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) [If yes, give war or date of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Estella Evering, 8027 Phila Road.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. DUE TO		ARTERIOSCLEROTIC C.V. disease		INTERVAL BETWEEN ONSET AND DEATH 1953			
(b) DUE TO		Arteriosclerosis, generalized		1953			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY , 19 53 , to July-11 , 19 58 , that I last saw the deceased alive on 7-10-58 , 19 58 , and that death occurred at 57 M, from the causes and on the date stated above. ACTUAL SIGNATURE Benjamin B. Moses, M.D.		ADDRESS (Street, city or town, state) 448 N. Luzerne Avenue		DATE SIGNED 7/12/58			
PHYSICIAN'S NAME (Type) Benjamin B. Moses		22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery		22d. LOCATION (City, town or county) Baltimore, Maryland		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery		22d. LOCATION (City, town or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE JUL 16 '58		24b. REGISTRAR'S SIGNATURE Asst. m.s.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7751 CERTIFICATE OF DEATH

Reg. Dist. No.

07741

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. LENGTH OF STAY IN lb Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3321 WILLOUGHBY R				d. STREET ADDRESS 3321 WILLOUGHBY Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip Lee SELLMAN		First	Middle	Last	4. DATE OF DEATH July 10 1958	Month	Day	Year	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1900	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body & Tender		10b. KIND OF BUSINESS OR INDUSTRY AUTO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John +1 SELLMAN		14. MOTHER'S MAIDEN NAME MARY E Bosse							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS Philip L. SELLMAN SAME		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Chronic enlarged heart failure				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
		Hypertension arterio-sclerotic heart disease				15 yrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Never secondary anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4301 M		20f. (City or town) BALTO		(County)	(State)
21. I certify that I attended the deceased from _____, July 10, 1958 , to _____, July 10, 1958 , that I last saw the deceased alive on _____, July 10, 1958 , and that death occurred at _____, 4301 M , from the causes and on the date stated above. ACTUAL SIGNATURE Elliott Harris								ADDRESS (Street, city or town, state) 8100 HARFORD RD, BALTO, MD	
PHYSICIAN'S NAME (Type) S. ELLIOTT HARRIS								DATE SIGNED 7/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 14-1958		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD		22d. LOCATION (City, town, or county) BALTO		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE CHAS F. EVANS & SON		ADDRESS 8802 HARFORD RD		24a. REC'D BY REGISTRAR JUL 14 1958		24b. REGISTRAR'S SIGNATURE Asst. Reg.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

117742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
BALTO Co MD MARYLAND		a. STATE North Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
DUNDALK MD 10A9		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		DUNDALK BALTO Co MD	
d. STREET ADDRESS 403 6th. Washington NC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosa		First	Middle
		Last	
		4. DATE OF DEATH	Month Day Year
		1/16/58	19
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
f. Fr		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/2/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
James W Gunn		Alice J. Dunston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
(If yes, give war or dates of service)		726-20-3057 Mr E. PROGHTS Queenland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 1955	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH some	
423.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 7-17-58	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Jack C Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7/17/58		22b. DATE THEREOF ADDRESS	
22c. NAME OF CEMETERY OR CREMATORIAL Oakdale Cemetery		22d. LOCATION (City, town, or county) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE J. G. Falvey & Sons 1318 Light		24a. REC'D BY REGISTRAR DATE JUL 18 '58	
		24b. REGISTRAR'S SIGNATURE Allie L. Smith	

5

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

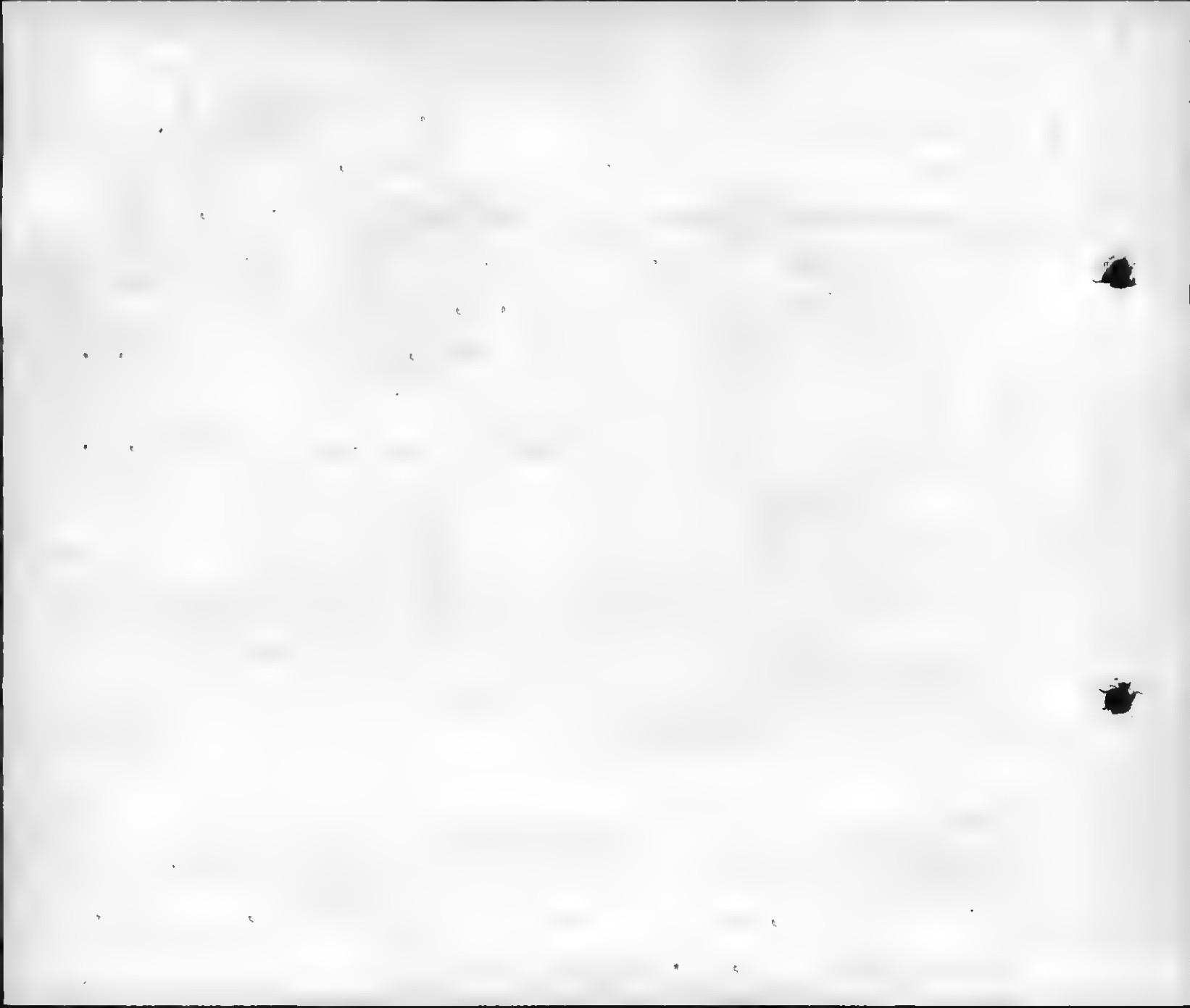
07743

7752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		b. COUNTY <i>East</i>	
c. LENGTH OF STAY IN 1b 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home of Maryland		d. STREET ADDRESS Woodholme & Rositerstown Rds.,	
3. NAME OF DECEASED (Type or print) Emma		First J.	Middle Spence
4. DATE OF DEATH July 17	Month July	Day 17	Year 1958
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1865
9. AGE (In years from birthday) 92	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	10b. KIND OF BUSINESS OR INDUSTRY seamstress	11. BIRTHPLACE (State or foreign country) Ontario, Canada	12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Adam Spence		14. MOTHER'S MAIDEN NAME Mary Curry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Records of Presbyterian Home Towson 4, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>for a. s.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <i>Chronic congestive heart failure</i>		6 mos	
(c) DUE TO <i>Arteriosclerotic cardio-vascular disease</i>		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1 , 1958, to July 17 , 1958, that I last saw the deceased alive on July 16 , 1958, and that death occurred at 6 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) 7215 York Rd Bel Air MD	
ACTUAL SIGNATURE <i>Sidney J. Venable Jr.</i>		DATE SIGNED <i>12/11/58</i>	
PHYSICIAN'S NAME (Type) SIDNEY J. VENABLE JR. MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Stone Chapel
22d. LOCATION (City, town, or county) Owings Mills, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE JUL 21 '58	24b. REGISTRAR'S SIGNATURE <i>John O. Mitchell</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

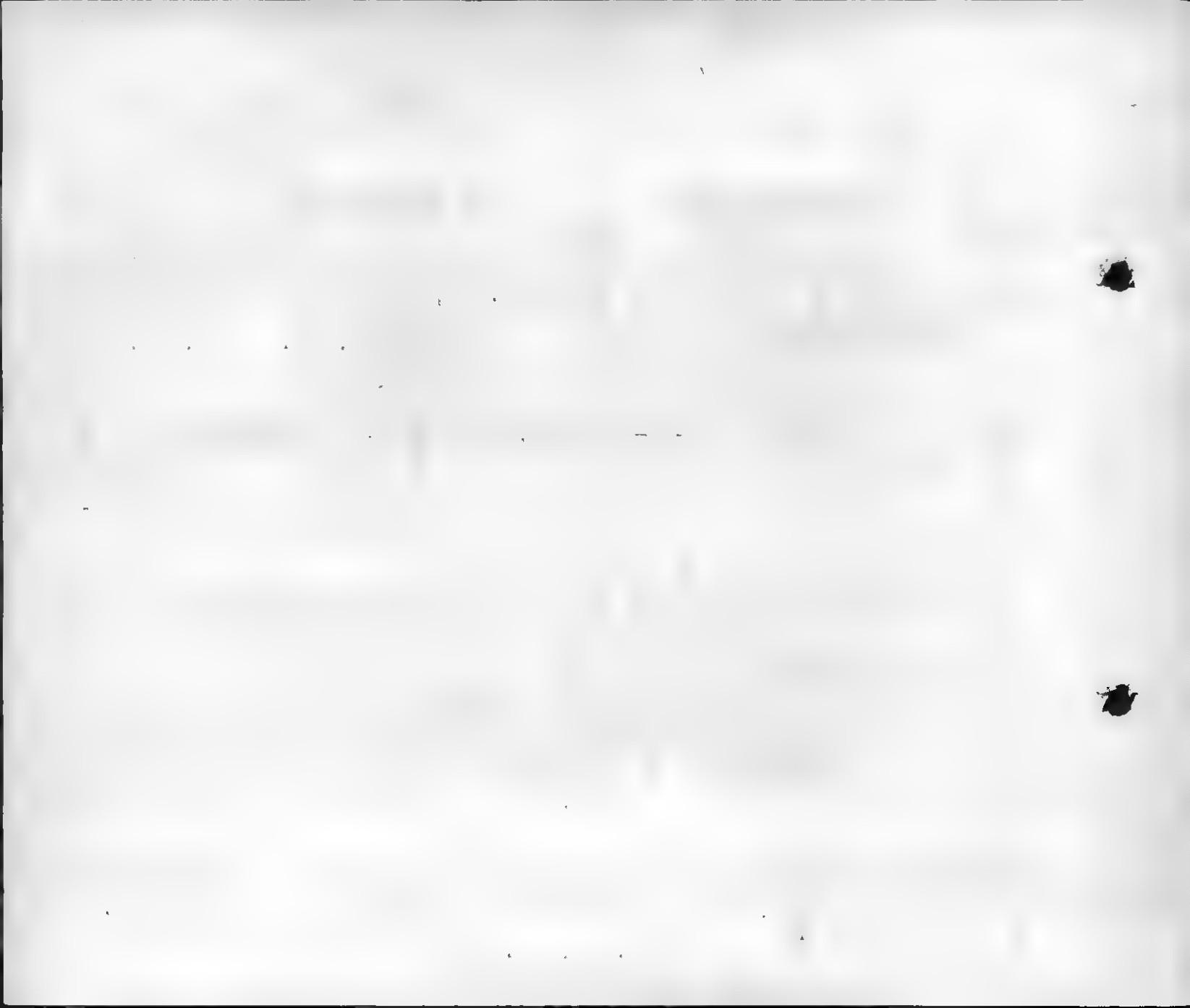
7753

CERTIFICATE OF DEATH

07744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		d. STREET ADDRESS 153 Lourdes Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 153 Lourdes Road				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry J. Sprole	Middle	Last	4. DATE OF DEATH	Month July	Day 26,	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1899		9. AGE (In years at birthday yrs.) 58	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past 5 years, working life, even if retired) Retired Fireman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sam Sprole		14. MOTHER'S MAIDEN NAME Anna Costello					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) Yes WWI Navy		16. SOCIAL SECURITY NO. 214-38-1770		17. INFORMANT Mrs. Ruby Sprole		Address 153 Lourdes Road 21	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 4 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Arterio Sclerosis				10 years	
DUE TO (c)		Hypertension				12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 10, 1958 to July 26, 1958 , that I last saw the deceased alive on July 25, 1958 , and that death occurred at 4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Morris A. Jacobs		ADDRESS (Street, city or town, state) M.D.				DATE SIGNED 7/28/58	
PHYSICIAN'S NAME (Type) Morris A. Jacobs							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 58		22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart of Jesus		22d. LOCATION (City, town, or county) German Hill Road Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 2829 Hudson St. 24, Md.		24a. REC'D. BY REGISTRAR AUG 1 58		24b. REGISTRAR'S SIGNATURE John Duda	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7754

CERTIFICATE OF DEATH

07745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5312 Patrick Henry Drive				d. STREET ADDRESS 5312 Patrick Henry Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Walter	Middle Starsoneck	Last	4. DATE OF DEATH July 8	Month	Day	Year 19 58
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29-1892	9 AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA,	
13. FATHER'S NAME Frank Starsoneck		14. MOTHER'S MAIDEN NAME Louise Cosgrove		Address Irene R. Starsoneck-5312 Patrick Henry Dr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.							
16. SOCIAL SECURITY NO. -----							
17. INFORMANT Irene R. Starsoneck-5312 Patrick Henry Dr							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hyperkinetic CH disease.							
(c) Purpura decompression.							
INTERVAL BETWEEN ONSET AND DEATH 3 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 9 to 8 , 19 58 , that I last saw the deceased alive on 6-27 , 19 58 , and that death occurred at 10 a. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1101 Patapsco Ave							
DATE SIGNED -----							
ACTUAL SIGNATURE 1437-1111-1111							
PHYSICIAN'S NAME (Type) Dr. Summers MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 11-58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. B. Skipper		ADDRESS 1300 Eutaw Pl.		24a REC'D BY REGISTRAR DATE JUL 11 58		24b REGISTRAR'S SIGNATURE A. L. Cooley	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7755

CERTIFICATE OF DEATH

07746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2yr5mthldys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1614 E. Fort Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Oscar	Middle	Last Steinitz, Jr.	4. DATE OF DEATH	Month July	Day 24	Year 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1902	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY freight office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oscar Steinitz, Sr.				14. MOTHER'S MAIDEN NAME Pauline Leidit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 217-03-2063		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular disease							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 19 58 to July 24, 19 58 that I last saw the deceased alive on July 24, 19 58 , and that death occurred at 12:00a M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE Stella Wachsler							
M.D. SPRING GROVE STATE HOSPITAL 7-24-58							
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.							
22a. BURIAL, CREMATION, REMOVALS (Specify) Burial		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Cemetery		22d. LOCATION (City, town, or county) Anne Arundel Md.	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Charles T. Dill		ADDRESS 1501 E. Fort Ave.		24. REC'D BY REGISTRAR JUL 28 '58		24b. REGISTRAR'S SIGNATURE Carl L. Smith	
(State)							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7756 CERTIFICATE OF DEATH

Reg. Dist. No.

07747

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 39 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		d. STREET ADDRESS 7307 Linden Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7307 Linden Ave				e. IS RESIDENCE ON A FARMS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Mamie	Middle Johnson	Last Stevens	4. DATE OF DEATH Month 7	Month 31	Day 1958	Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH About 65 yrs.	9. AGE (in years last birthday) About 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Baltimore County, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Johnson		14. MOTHER'S MAIDEN NAME Sally Jones						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-05-3121		17. INFORMANT Mr. Augustus Johnson - Home		Address 1428 Overlea Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral attack INTERVAL BETWEEN ONSET AND DEATH 12 hrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive arteriosclerotic changes		DUE TO (b) DUE TO (c)	hypertensive arteriosclerotic changes, circulatory disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1428 Overlea Ave.		20f. (City or town) Baltimore	(County) Baltimore	(State) Md
21. I certify that I attended the deceased from Sept 1958 to July 31, 1958 , that I last saw the deceased alive on July 31, 1958 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1428 Overlea Ave. DATE SIGNED 8-1-58								
ACTUAL SIGNATURE Rigler		PHYSICIAN'S NAME (Type) Dr. Richard R. Rigler						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 3, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Baltimore County, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock		ADDRESS 1428 Overlea Ave.		24a. REC'D BY REGISTRAR Aug 5 '58		24b. REGISTRAR'S SIGNATURE W.L. Smith		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7757

CERTIFICATE OF DEATH

07748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 1407 - 39th Street	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Oscar Harrison		4. DATE OF DEATH July 18	Month Day Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1870
9. AGE (In years last birthday) 87 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plasterer	
11. KIND OF BUSINESS OR INDUSTRY Construction		12. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 577 26 3045	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Cardiac failure Arterioscler. Cardio Vasc. disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958, to 7/18, 1958, that I last saw the deceased alive on 7/18, 1958, and that death occurred at 8:40 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE STELLA WACHSLER M.D. SPRIN: GROVE STATE HOSPITAL PHYSICIAN'S NAME (Type) STELLA WACHSLER Catonsville 28, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/58	
22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		22d. LOCATION (City, town, or county) Washington D. C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE JUL 21 '58	
		24b. REGISTRAR'S SIGNATURE Q. L. French	

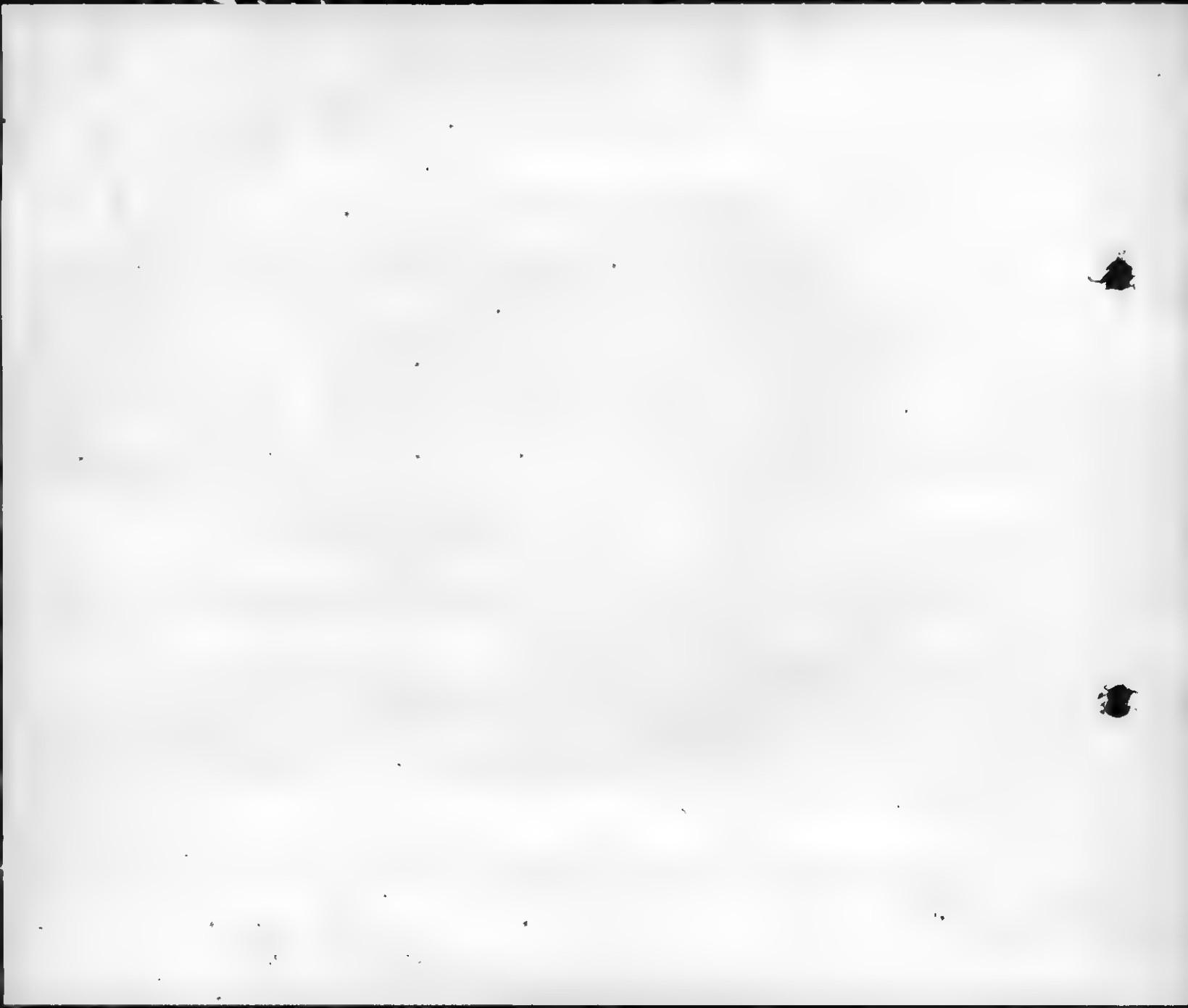
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician and complete in the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 07749		
7758 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home					d. STREET ADDRESS 215 Oakdale Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FREDERICK H. STRICKLAND					4. DATE OF DEATH July 11, 1958					Month Day Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1886		9. AGE (in years lost birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President					10b. KIND OF BUSINESS OR INDUSTRY Insurance					11. BIRTHPLACE (State or foreign country) Penna.		
13. FATHER'S NAME Frank T. Strickland					14. MOTHER'S MAIDEN NAME Anne Mary Riley					12. CITIZEN OF WHAT COUNTRY? Mrs. Edith M. Strickland - 215 Oakdale Rd.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO.					Address		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 445A					17. INFORMANT Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH (5 days)		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. b) Hypertensive Cardiovascular Disease												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug. , 1957, to July 11, 1958 that I last saw the deceased alive on July 10, 1958 , and that death occurred at 6 AM , from the causes and on the date stated above										ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE William F. Pearce M.D. 2105A Charles St.												
PHYSICIAN'S NAME (Type) WILLIAM F. PEARCE												
22a. BURIAL/CREMATION REMOVAL (Specify) Removal		22b. DATE THEREOF 7/11/58		22c. NAME OF CEMETERY OR CREMATORIUM Ivy Hill Cem.			22d. LOCATION (City, town, or county) Germantown, Pa.			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Siekner & Sons Baetzel					24a. REC'D BY REGISTRAR DATE JUL 14 '58					24b. REGISTRAR'S SIGNATURE Westover		



INSTRUCTIONS

TO ATTENDING PHYSICIAN [REDACTED] **HOSPITAL**: The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely signed in by the funeral director, its third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

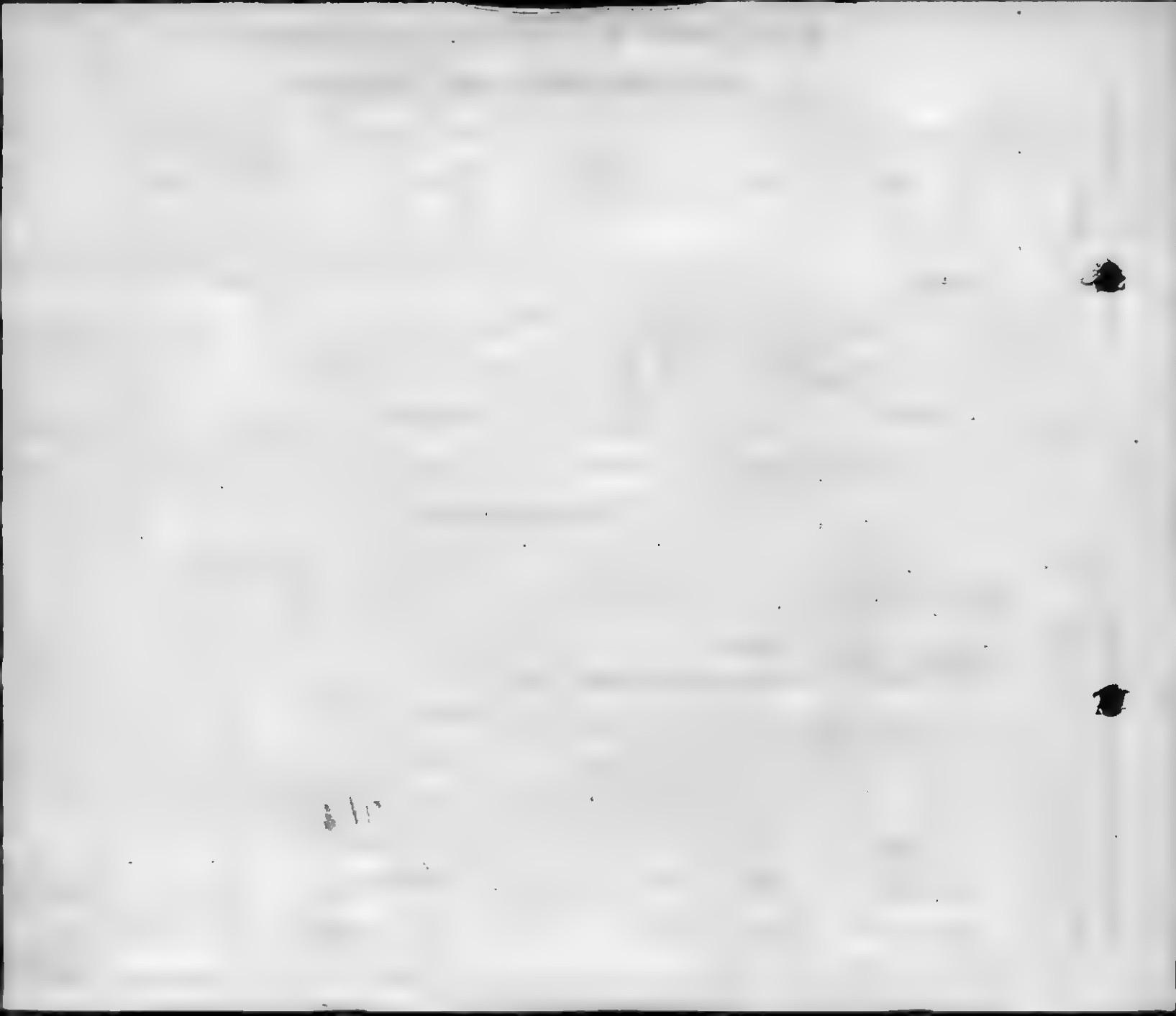
CERTIFICATE OF DEATH

07750

Reg. Dist. No.

7759

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
Baltimore	79	BALTIMORE	79
HOSPITAL OR INSTITUTION OR STREET ADDRESS	627 Plymouth Rd		
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH	
Edith May Struble		July 15 1958	
SEX FEMALE	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 18 July 1886
71 yrs.	9. AGE last birthday 71	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE MD
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
New		Edith May Struble	
13. FATHER'S NAME Charles C. Struble		14. MOTHER'S MAIDEN NAME Isabelle Fenton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Edith May Struble 627 Plymouth Rd		18. MEDICAL CERTIFICATION Myocarditis	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
I IMMEDIATE CAUSE (A) Myocarditis			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 1 1958 to July 15 1958 that I last saw the deceased alive on July 15 1958, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
SIGNATURE C. J. Meudelis			
ADDRESS (Street, city, town, state) 651 N Bendall St			
DATE SIGNED 7/15/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 18 July 1958	
NAME OF CEMETERY OR CREMATORIAL FOY DON PARK CEM.		LOCATION (City, town, or county) BALTIMORE MD	
24. REC'D BY REGISTRAR Registrar's Signature		25. FUNERAL DIRECTOR'S SIGNATURE W. H. C. Meudelis Particulars	
DATE JUL 17 '58		ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use by the funeral director, and page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18										Reg. Dist. No. 07751			
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY BALTO MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD b. COUNTY City								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gwyn Oak					c. LENGTH OF STAY IN 1b								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AUGSBURG HOME					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO								
3. NAME OF DECEASED (Type or print) Anna M Sturmfelsz					d. STREET ADDRESS Not given					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Feb 22, 1877		9. AGE (In years from birthday) 81 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE					10b. KIND OF BUSINESS OR INDUSTRY NONE					12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John					14. MOTHER'S MAIDEN NAME MARGARET HAFSEK								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. —					Address Records AUGSBURG Home			
17. INFORMANT										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Interstitial Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to with Atrial fibrillation. (c) Due to Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterial Sclerosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from July 14, 1949, to July 8, 1958, that I last saw the deceased alive on July 7, 1958, and that death occurred on July 8, 1958, from the causes and on the date stated above.					ADDRESS (Street, city or town, state) M.D. 4108 Liberty Hts, Balt., Md. - 7 May 79-58					DATE SIGNED			
ACTUAL SIGNATURE Earl L. Chambers					PHYSICIAN'S NAME (Type) Earl L. Chambers -					22d LOCATION (City, town, or county) (State)			
22e. BURIAL, CREMATION, REMOVAL (Specify) 7-11-58					22f. NAME OF CEMETERY OR CREMATORIUM KENNEDY CEM.					22g. REC'D BY REGISTRAR DATE JUL 14 '58			
23. FUNERAL DIRECTOR'S SIGNATURE Paul A. HEEMANN					ADDRESS HARP					24b. REGISTRAR'S SIGNATURE Alvin French			



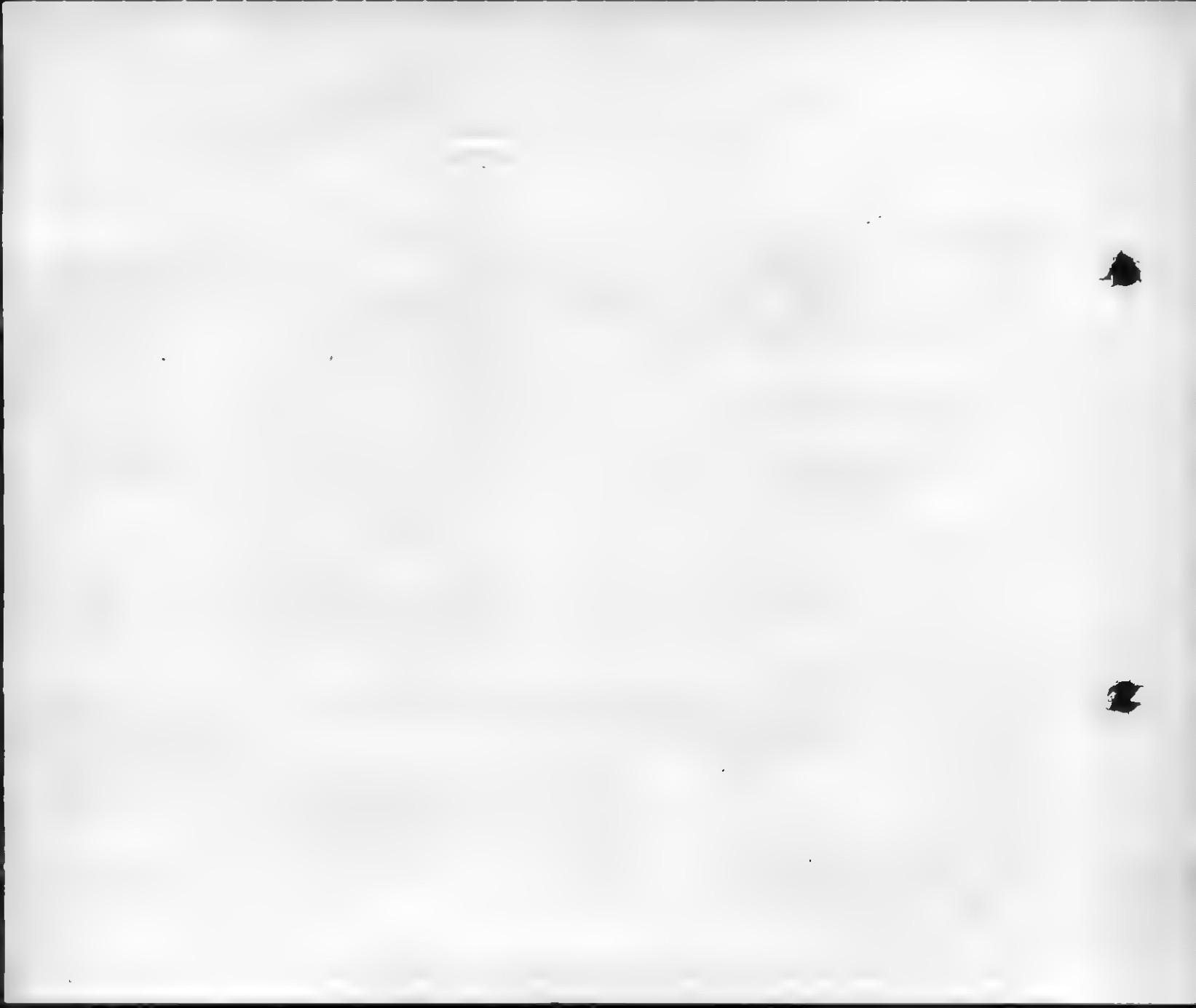
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7620 CERTIFICATE OF DEATH

07752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		b. COUNTY <i>Dundalk</i>				
c. LENGTH OF STAY IN 1b <i>17 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1806 Walnut Avenue</i>		d. STREET ADDRESS <i>1806 Walnut Ave</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Alexander</i>	Middle <i>M</i>	Last <i>Swiontek</i>			
4. DATE OF DEATH	Month <i>7</i>	Day <i>- 18</i>	Year <i>1958</i>			
5. SEX	6. COLOR OR RACE <i>Male</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>II-18-1901</i>			
9. AGE (In years lost birthday) <i>56 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly man</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Martin Co</i>	10c. BIRTHPLACE (State or foreign country) <i>Hazeltown Pa.</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Mathew Swiontek</i>	14. MOTHER'S MAIDEN NAME <i>Anna ?</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>17106146</i>	17. INFORMANT <i>Thresa M. Swiontek</i>	Address <i>1806 Walnut Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i>						
DUE TO <i>ARTERIOSCLEROTIC C. V. DIS.</i>						
INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <i>HYPERTENSION</i> (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>July 18, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6214 Holabird Ave</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>July 18, 1958</i> , to <i>July 18, 1958</i> , that I last saw the deceased alive on <i>May 1958</i> , and that death occurred at <i>150 P.M.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Stephen C. Mackowiak</i>						ADDRESS (Street, city or town, state) <i>6214 Holabird Ave</i>
PHYSICIAN'S NAME (Type) <i>STEPHEN C. MACKOWIAK</i>						DATE SIGNED <i>7-19-58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-22-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Sacred Heart of Mary</i>	22d. LOCATION (City, town, or county) <i>Baltimore Maryland</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Sabrowski, Balt. 24, Md.</i>	ADDRESS <i>Mr. Sabrowski, Balt. 24, Md.</i>	24a. REC'D BY REGISTRAR <i>JUL 21 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Ans. Sabrowski</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

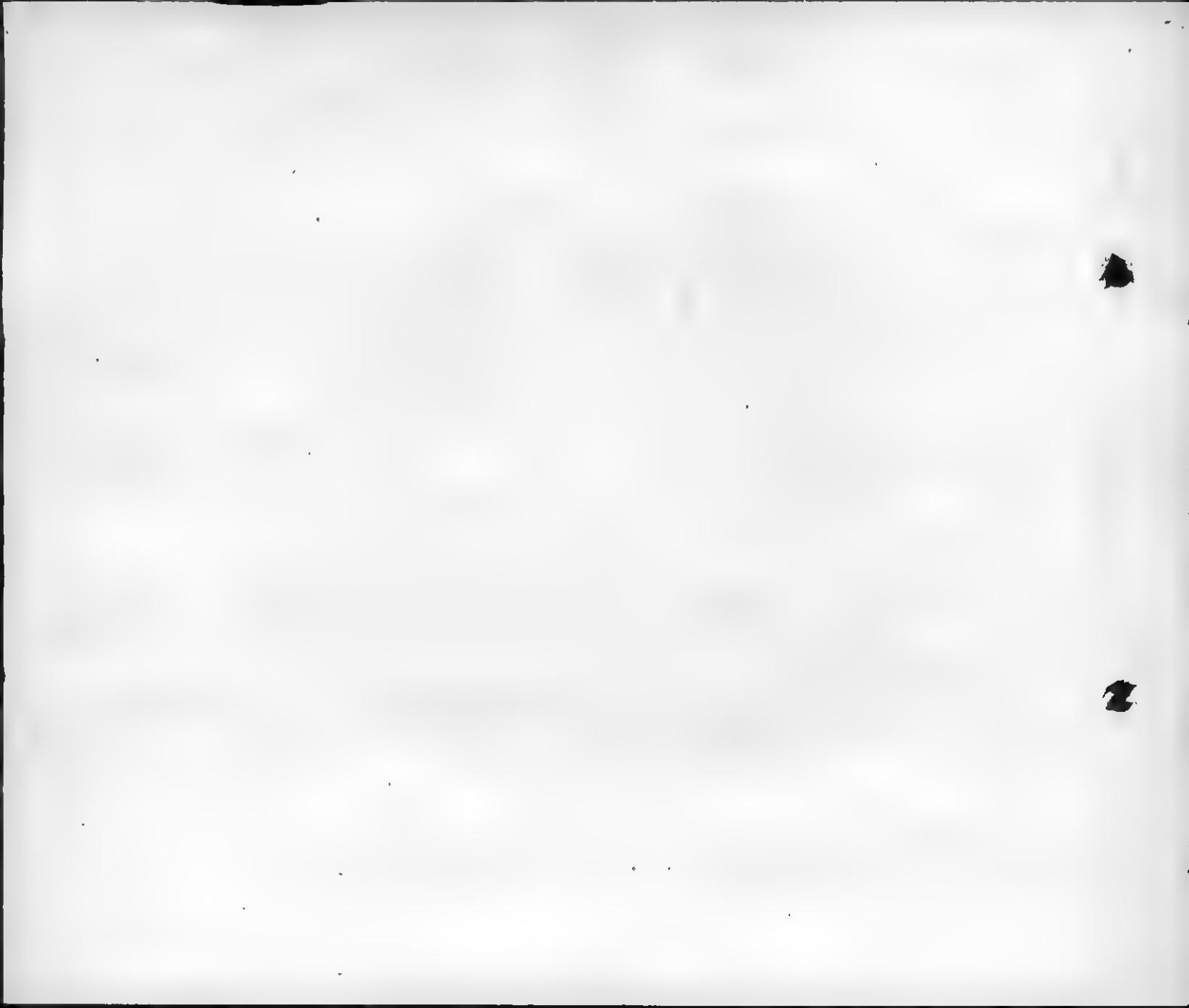
2761

CERTIFICATE OF DEATH

117753

Rsg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville, Md.		d. STREET ADDRESS Jarrettsville, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Samuel	Middle James	Last Thomison	4. DATE OF DEATH July 16	Month July	Day 16	Year 19 58
5. SEX male		6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1919	9. AGE (In years last birthday) 39	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician		10b. KIND OF BUSINESS OR INDUSTRY medicine		11. BIRTHPLACE (State or foreign country) Belaware		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Samuel Thomison, Sr.				14. MOTHER'S MAIDEN NAME Jane Harrington				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Delirium tremens DUE TO (c) Chronic alcoholism								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Wilmington (State) Delaware		
21. I certify that I attended the deceased from July 11, 1958 , to July 16, 1958 , that I last saw the deceased alive on July 16, 1958 , and that death occurred at 5:30 a.m. from the causes and on the date stated above								
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 7-16-58 DATE SIGNED								
ACTUAL SIGNATURE Stella Wachsler								
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 18, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Louder Brandywine Cem		22d. LOCATION (City, town, or county) Wilmington Delaware (State) Delaware		
23. FUNERAL DIRECTOR'S SIGNATURE Carlton E. Knott Jarrettsville Md.				ADDRESS Jarrettsville 28, Maryland		24a. REC'D BY REGISTRAR DATE JUL 21 '58		
						24b. REGISTRAR'S SIGNATURE Carlton E. Knott		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7762

CERTIFICATE OF DEATH

07754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 10 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nurs. Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) DELIA A. THOMPSON		4. DATE OF DEATH JULY 19, 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 78 yrs.
13. FATHER'S NAME Hugh Foley		14. MOTHER'S MAIDEN NAME Mary Thornton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Catherine McFaul
			Address 2609 Grogans Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) metastatic Ca of Brain 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinoma of Rectum DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Month Day Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-11-1958 to 7-19-1958 , that I last saw the deceased alive on 7-19-1958 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 6209 Frederick Ave. DATE SIGNED 7-21-58	
ACTUAL SIGNATURE Wilmer K. Gallagher		M.D.	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1958	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemt
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		ADDRESS 3000 E. Baltimore St.	24a. REC'D BY REGISTRAR JULY 23 '58
			24b. REGISTRAR'S SIGNATURE R. L. Schenck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached from this certificate and given to the funeral director. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7763

CERTIFICATE OF DEATH

07755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT		c. LENGTH OF STAY IN lb 55 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT (19)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1321 FOREST Rd		d. STREET ADDRESS 1321 FOREST Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle THOMPSON	Last	4. DATE OF DEATH	Month 7/8/58	Day	Year 19
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1895	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY STEEL WORK		11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARCHIE THOMPSON		14. MOTHER'S MAIDEN NAME JANE T BRONSTON		Address 111 N. JEFFERSON ST., BALTIMORE, MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 1367-7698		17. INFORMANT J. M. THOMPSON		18. INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Generalized Carcinosis		Carcinosis of Larynx			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) D' STREET - SPARROWS POINT		20f. (City or town) (County) (State) BALTIMORE CO. MD	
21. I certify that I attended the deceased from July 1, 1958 to July 5, 1958 , that I last saw the deceased alive on July 5, 1958 , and that death occurred at 7:35A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) D' STREET - SPARROWS POINT DATE SIGNED 7/8/58							
ACTUAL SIGNATURE James Means, M.D.		M.D.					
PHYSICIAN'S NAME (Type) JAMES MEANS, M.D.		11		11		11	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE-THEREOF 7/10/58		22c. NAME OF CEMETERY OR CREMATORIUM OTIS CEMET.		22d. LOCATION (City, town, or county) BALTIMORE CO. MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Health Service		ADDRESS Baltimore, Maryland, 1958		24a. REC'D BY REGISTRAR DATE : July 11, 1958		24b. REGISTRAR'S SIGNATURE DeLoach	

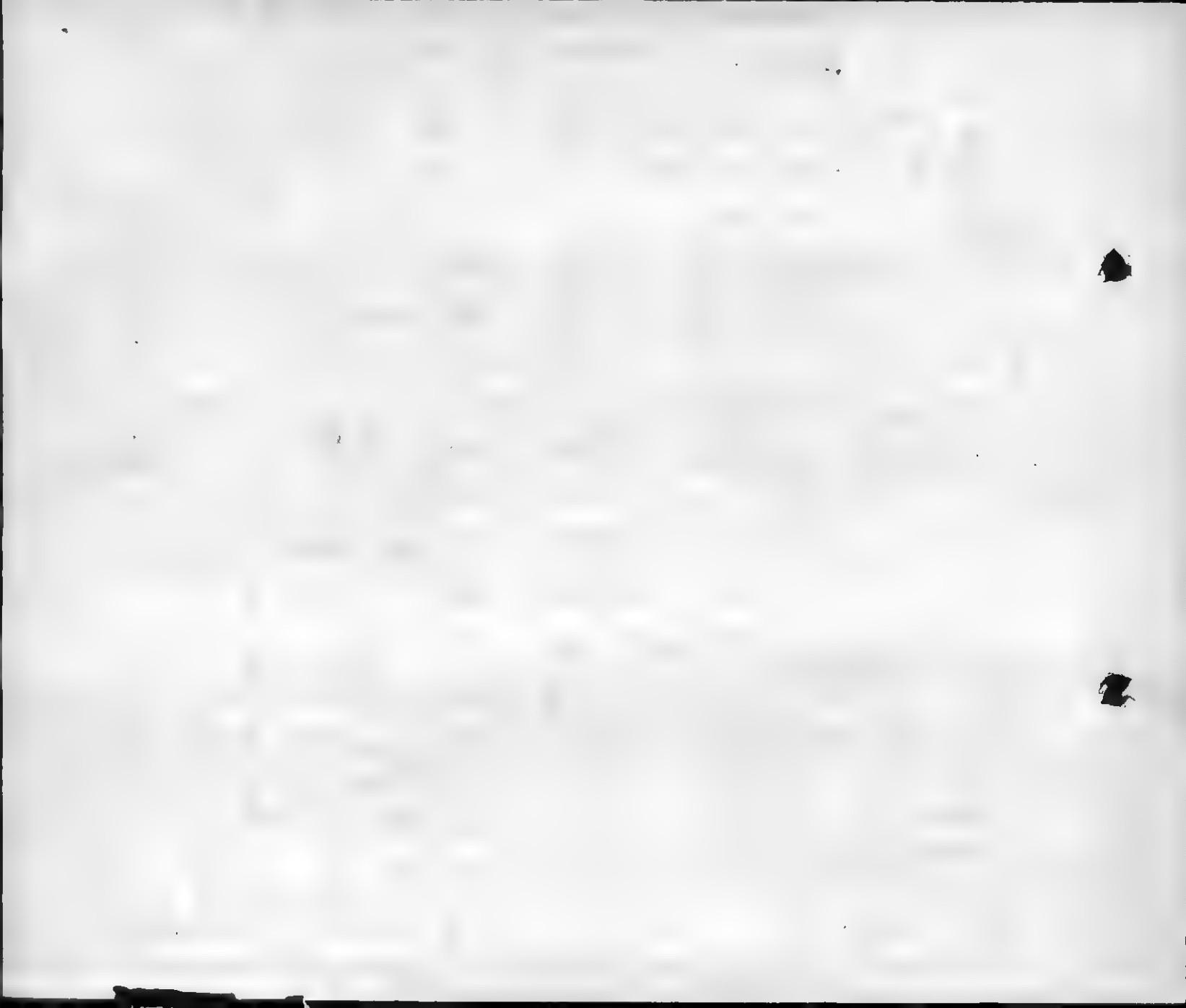
1
D
M

1. OBTAINING PHYSIAN: The law requires that the death certificate be executed within 24 hours after death. Log 4

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, signed by the funeral director, page 3 should be detached for use on a burial permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

3. may be retained by the hospital or attending physician.

VS A15 (4)
ISM 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07756

Reg. Dist. No.

7764

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	c. LENGTH OF STAY IN lb 19 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2623 Wendover Road	14	d. STREET ADDRESS 2623 Wendover Road			
3. NAME OF DECEASED (Type or print) Urath	First E.	Middle Thornton	4. DATE OF DEATH July 29, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1898		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Louis T. Wilson		14. MOTHER'S MAIDEN NAME Keziah E. Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Harry M. Thornton		
			Address 2623 Wendover Road 14		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hr			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		<i>Pulmonary Edema</i>			
(b)		<i>Cardiac Failure</i>			
DUE TO (c)		<i>Cerebral vascular accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Atherosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore Co. Maryland	(County)	(State)
21. I certify that I attended the deceased from <u>from July 29, 1958, to 11:45 P.M. July 29, 1958</u> , that I last saw the deceased alive on <u>29 July 1958</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>7527 Belair Rd</u> BALTIMORE, MD DATE SIGNED <u>7-31-58</u>					
ACTUAL SIGNATURE <u>John C. Hyde</u>		PHYSICIAN'S NAME (Type) <u>John C. Hyde M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 2, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Park	22d. LOCATION (City, town, or county) Baltimore Co. Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road	24a. REC'D BY REGISTRAR DATE AUG 4 '58	24b. REGISTRAR'S SIGNATURE <u>W.L. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Page 3 should be detached for use by the funeral director.

2

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

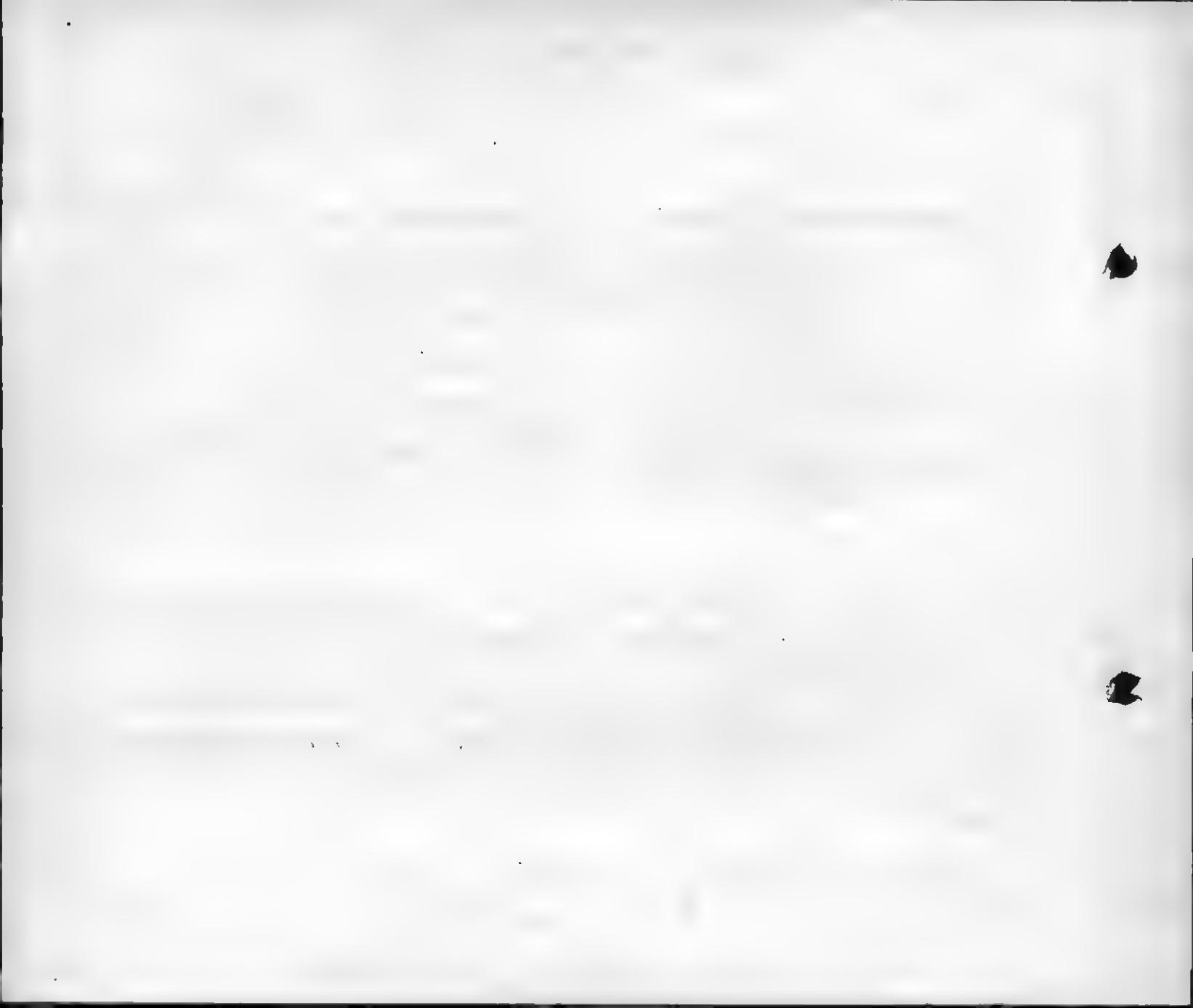
07757

7765

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
<i>Baltimore</i>		<i>Maryland</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Eatonville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>House in Penes</i>		<i>Baltimore</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>4011 Springdale Ave</i>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
<i>MORRIS</i>		<i>H TUMBLER</i>	
First		Middle	Last
5. SEX		6. COLOR OR RACE	
<i>Male</i>		<i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<i>85 yrs</i>		<i>Real Estate</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Austria</i>		<i>WSA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Not Known</i>		<i>Rebecca</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or date of service)			
17. INFORMANT		Address	
<i>Da Tumbler - son</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Cerebral Thrombosis</i>			
DUE TO			
<i>Arterio Sclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>about 45 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b)			
DUE TO			
<i>Coronary Insufficiency</i>			
Many Years			
(c)			
<i>Arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Gastric Ulcer</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that I attended the deceased from <i>12/20/1932</i> to <i>7/1/1958</i> , that I last saw the deceased alive on <i>4/30/1958</i> , and that death occurred at <i>8757</i> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED			
<i>Theodore H. Morrison M.D. 11 E Chase St. Baltimore Md. 7/1/58</i>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
<i>Theodore H. Morrison</i>		<i>Theodore H. Morrison</i>	
22a. CERIAL, CREMATON, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Cremation</i>		<i>7-2-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
<i>Hebrew Friendship</i>		<i>Baltimore Md</i>	
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Jack Lewis Jr.</i>		<i>2100 Catons Place</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUL 2 '58		<i>Alt eacch</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17758

7766

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Res dence before adm ission) a. STATE Illinois		b. COUNTY Hancock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warsaw		d. STREET ADDRESS 319 Polk Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUTION 120 Westbury Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Rosa	Middle Lina	Last Uhlig	4. DATE OF DEATH	Month July	Day 25	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1896	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail grocer-Retired		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery		11. BIRTHPLACE (State or foreign country) Germany		12 CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Grim				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Kate M. Smith (dau) 120 Westbury Rd., Lutherville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6-7 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Rheumatoid Arthritis; Syringomyelia.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I attended the deceased from June 29, 1958 to July 25, 1958 , that I last saw the deceased alive on July 25, 1958 , and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Vernon M. Smith, M.D. 1526 York Road, Lutherville, Md. 7-25-58							
DATE SIGNED 7-25-58							
ACTUAL SIGNATURE Vernon M. Smith, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 26, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc				ADDRESS 1050 York Rd.		24a. REG'D BY REGISTRAR DATE JUL 31 1958	
						24b. REGISTRAR'S SIGNATURE Alfred J. Deuch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached from the certificate as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

2

DIB
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 1 File No. 17-21-58 et
CERTIFICATE OF DEATH

Reg. Dist. No. 07759

1. PLACE OF DEATH a. COUNTY Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bauers Farm Road (At home)		d. STREET ADDRESS 7127 Greenwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy		First E.	Middle Umstead
Last		4. DATE OF DEATH July 14, 1958	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 12, 1921		9. AGE (In years last birthday) 37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labatory Technician		10b. KIND OF BUSINESS OR INDUSTRY Kappers Co.	
11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Arthur Rickard		14. MOTHER'S MAIDEN NAME Betty Oakley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no or unknown) No		16. SOCIAL SECURITY NO. 072-16-2108	
17. INFORMANT Mr. Charles L. Lynch		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX DUE TO 17/1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 23 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1941 , 19, to 7/14/58 , 19, that I last saw the deceased alive on 7/14/58 , 19, and that death occurred at 11:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7422 Eastern Ave Baltimore Md. DATE SIGNED 7/16/58	
ACTUAL SIGNATURE Max Baum		PHYSICIAN'S NAME (Type) Max Baum	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Gardens Of Faith		22d. LOCATION (City, town, or county) (State) Trump Hill Rd. Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassalle Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE JUL 18 '58		24b. REGISTRAR'S SIGNATURE Albert couch	



INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
HOSPITAL: After this copy of this certificate has been executed, send a copy to the attending physician.
MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied.
Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

17760

7768 CERTIFICATE OF DEATH1. NAME OF DECEASED
(Type or Print)

Walter Underwood

2. DATE
OF
DEATH

July 31, 1958

3. PLACE OF DEATH:

A. Baltimore

B. Maryland Baltimore

C. FULL NAME OF HOSPITAL OR INSTITUTION

Baltimore County

D. STREET ADDRESS

110 OAKLEE VILLAGE

4. USUAL RESIDENCE (Where deceased lived if institution address)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. STREET ADDRESS (If rural, give location)

E. CITY OR TOWN

F. OUTSIDE CORPORATE LIMITS, WRITE BOROUGH AND TOWNSHIP

G. CITY OR TOWN

H. OUTSIDE CORPORATE LIMITS, WRITE BOROUGH AND TOWNSHIP

c. Length of stay in Baltimore

Life

Yrs.
Mo.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED. (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

CHIEF PLUMBING INSPECTOR MUNICIPAL

13. FATHER'S NAME

Henry Underwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If Yes, give war or dates of service)

No None

16. SOCIAL SECURITY NO

18. M.M.Y.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

NAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES NO 21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from May 5, 1958 to July 31, 1958 that I last saw the deceased alive on July 24, 1958, and that death occurred at 3 A.m., from the causes and on the date stated above.

23A. SIGNATURE

Basil Baggott M.D.

23B. ADDRESS

3812 Greenmount Ave

23C. DATE SIGNED

July 31, 1958

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial 8-4-58

24B. DATE

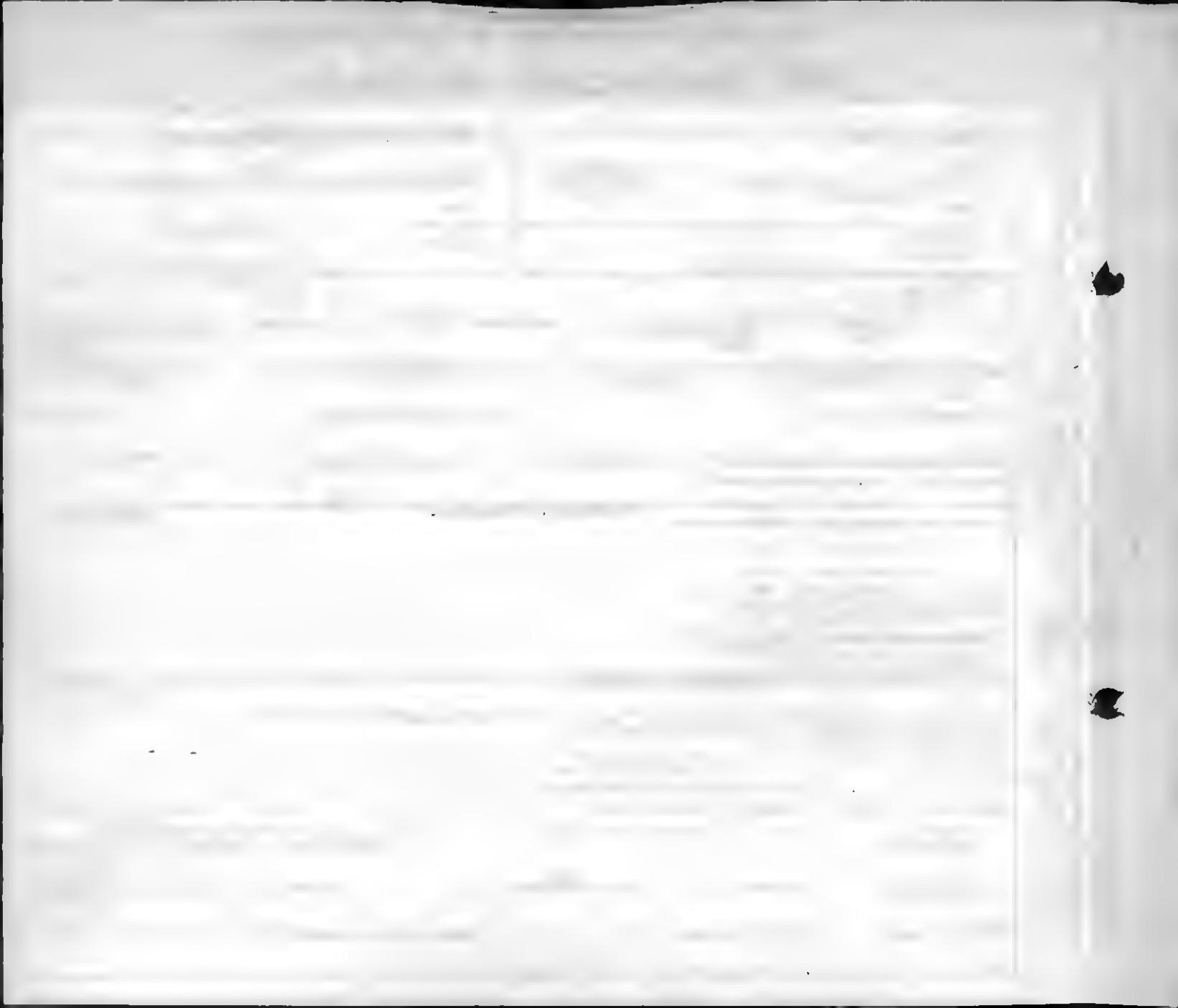
Lorraine Park

24C. NAME OF CEMETERY OR CREMATORIUM

Balto. County Md.

24D. LOCATION (City, town or county)

(State)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7769

CERTIFICATE OF DEATH

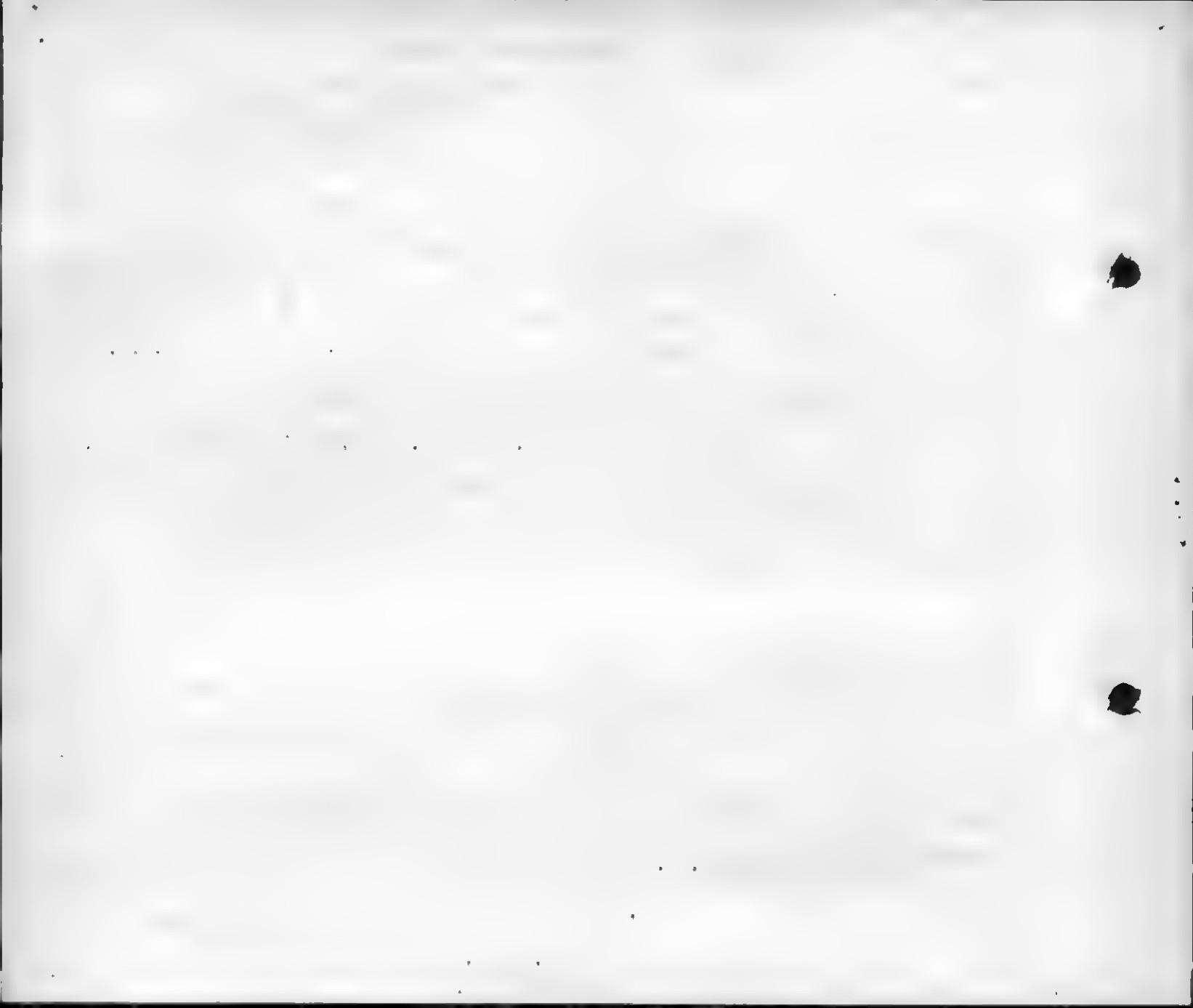
Reg. Dist. No.

07761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 27 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle (MM)	Last VETERERAIME	
4. DATE OF DEATH	Month July	Day 6	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/91	
9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair Man	10b. KIND OF BUSINESS OR INDUSTRY Repair Shop	11. BIRTHPLACE (State or foreign country) Sicily, Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Verederaime	14. MOTHER'S MAIDEN NAME Teresa Rosso			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WHT	17. INFORMANT Clin.Rec.Vets.Admin.Hospital,Ft.Howard,Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER WITH WIDESPREAD 181.0 METASTASES				
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		
		DUE TO		
		(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 9, 1958, to July 6, 1958, and that death occurred at 3:05 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE <i>Armen Bogosian</i>		DATE SIGNED 7/6/58		
PHYSICIAN'S NAME (Type) ARMIN BOGOSIAN, M.D.				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 7/9/58	22c. NAME OF CEMETERY OR CREMATORIUM Balto. National Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Vernon Lemmon</i>	ADDRESS 4611 Park Heights, Balto.	24a. REC'D BY REGISTRAR JUL 8 '58	24b. REGISTRAR'S SIGNATURE <i>Albert Leach</i>	



1

TO DEPUTY MEDICAL EXAMINER: This certificate be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.

TO FUNERAL DIRECTOR: Page 3 be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

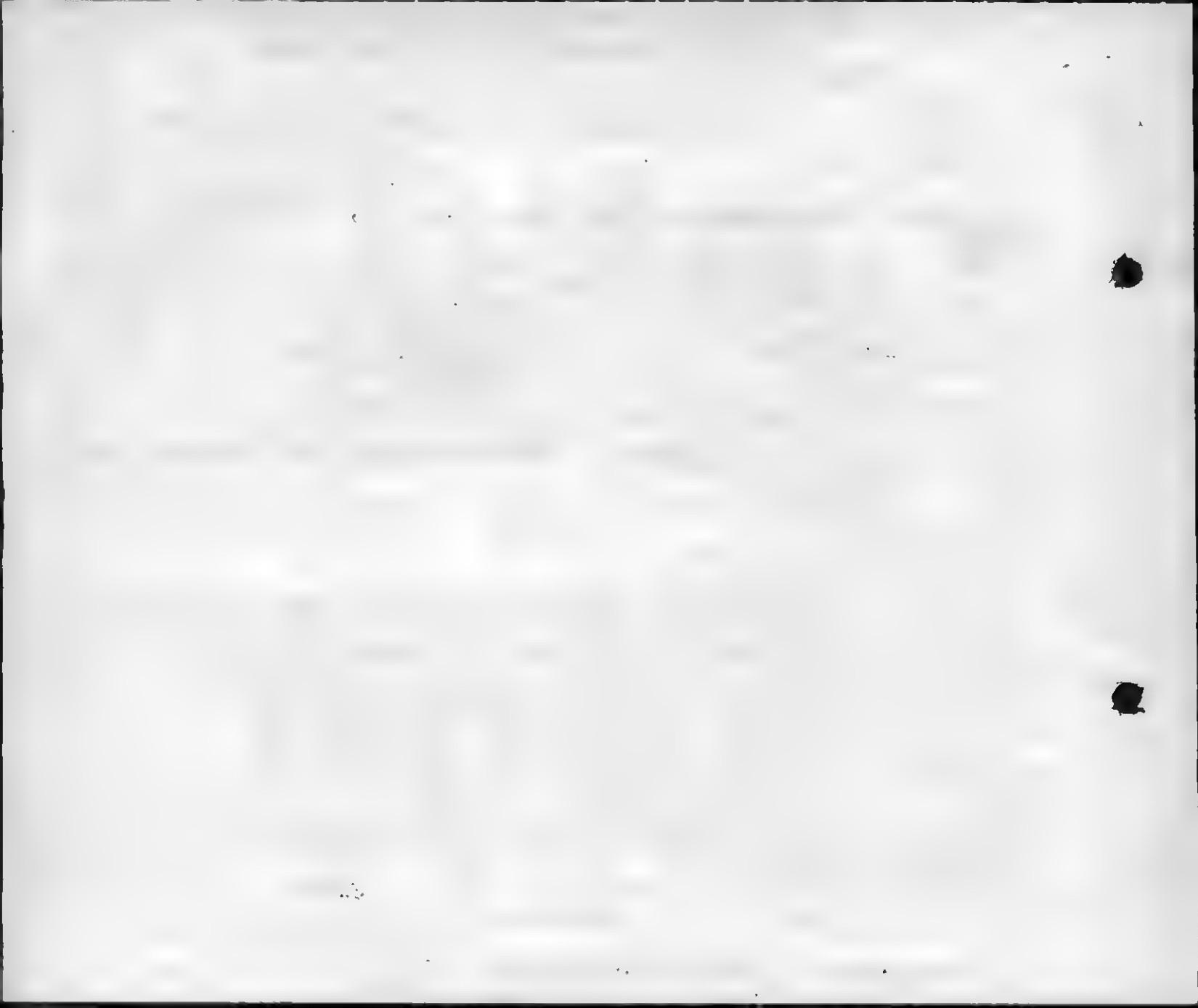
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07762

Reg. Dist. No.

7621

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNERS STATION		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X TURNERS STATION		d. STREET ADDRESS 119 Cypress Court		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CLEMENTS COVE (Water) (Rear of 612 PEACH ORCHID LANE) , TURNERS STATION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) RAYMOND		First	Middle	Last	4. DATE OF DEATH JULY 29 1958	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 8, 1941	9. AGE (in years last birthday) 16 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT-High School		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ROBERT VIRGIN		14. MOTHER'S MAIDEN NAME SADIE EDMONDS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ROBERT VIRGIN 119 CYPRESS COURT-Day Village		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 729.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 min								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped off an innertube in 20 feet of water						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clemente Cove	20f. (City or town) Turners Sta.	(County) Balto.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE JACK C. Collins		DATE SIGNED 7-30-58						
EXAMINER'S NAME (Type) JACK C. Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/2/58		22c. NAME OF CEMETERY OR CREMATORIUM MOUNT AUBURN CEMETERY		22d. LOCATION (City, town, or county) BALTIMORE, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES R. LAW 802 MADISON AVE.—BALTIMORE		24a. REC'D BY REGISTRAR JUL 31 '58						
		24b. REGISTRAR'S SIGNATURE Audrey						



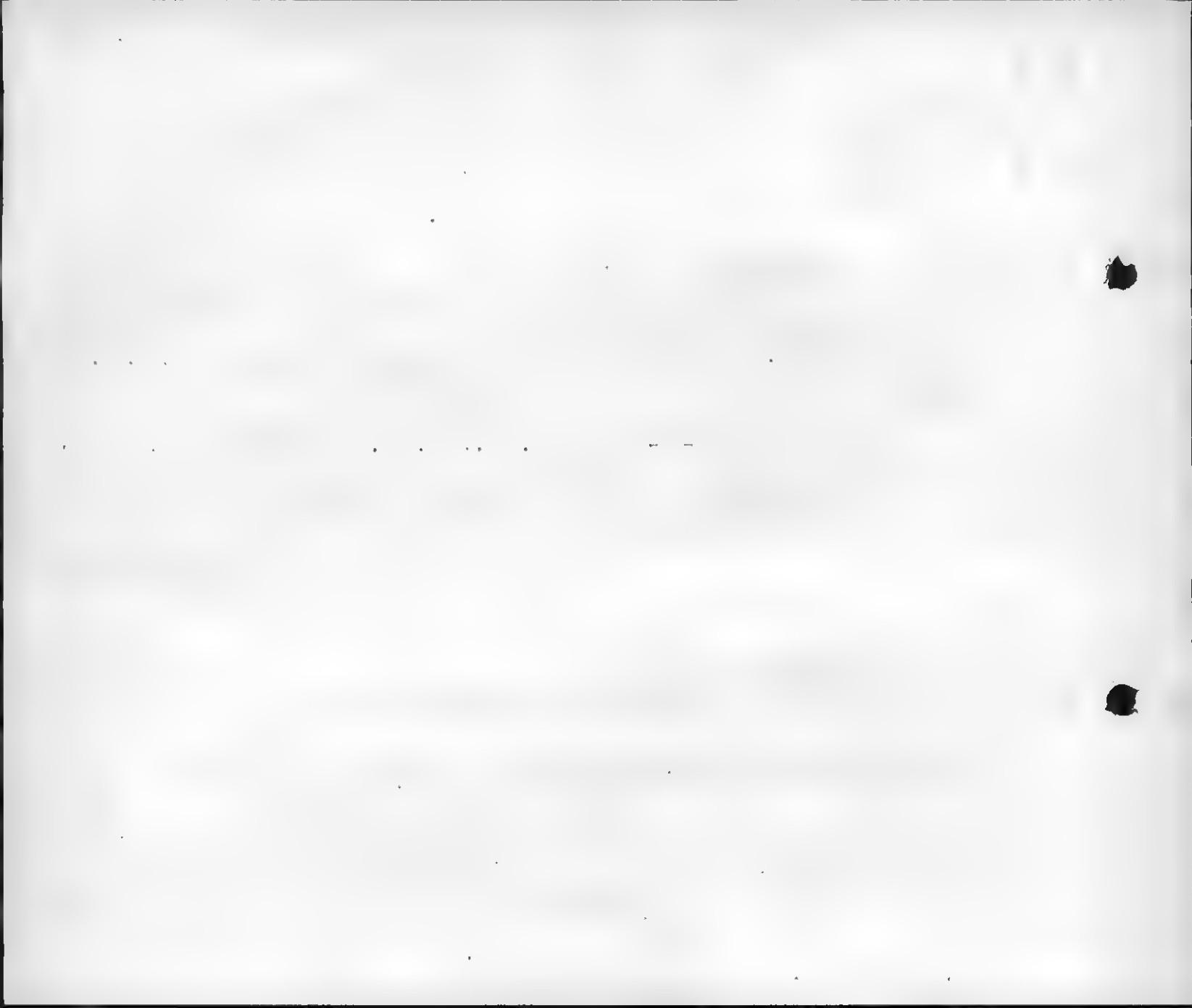
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07763

7770 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 91 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2408 E. Federal Street					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES		First H.	Middle VOSSELL	Last 	4. DATE OF DEATH July 28 1958	Month July	Day 28	Year 1958			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1882		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours 	Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper - Unempl.		10b. KIND OF BUSINESS OR INDUSTRY Brewing Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13. FATHER'S NAME John Vossell				14. MOTHER'S MAIDEN NAME Elizabeth Fallar							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW I 218-07-9612		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA WITH ABSCESS FORMATIONS, RIGHT						INTERVAL BETWEEN ONSET AND DEATH 6 DAYS					
XEROPIX LOWER LOBE Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ARTEROSCLEROTIC HEART DISEASE DUE TO (c)						UNKNOWN					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour b. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VAH, FORT HOWARD, MARYLAND		(County) 		(State) 	
21. I certify that I attended the deceased from April 28 1958 to July 28 1958 XXXXXX XXXXXXXX XXXXXXXX and that death occurred at 8:50 P.M. from the causes and on the date stated above. Chien Wei Lan ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.										ADDRESS (Street, city or town, state) 	DATE SIGNED 7/29/58.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-58		22c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Miller, Inc.		ADDRESS 2435 East Oliver St. Baltimore, Md.		24a. REC'D BY REGISTRAR AUG 4 '58		24b. REGISTRAR'S SIGNATURE Alfred					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial permit. Then please remove carbon papers. page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 07764		
7771 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 1mth10dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 606 Linard Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Vaughan Middle Samuel Last Ward			4. DATE OF DEATH July 22 1958		Month	Day	Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 10, 1872		9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman			10b. KIND OF BUSINESS OR INDUSTRY tobacco warehouse			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Celeste							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown			16. SOCIAL SECURITY NO. 214 22 8325			17. INFORMANT Records, SPRING GROVE STATE HOSPITAL			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH												
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost. (b) Arteriosclerotic cardiovascular disease												
DUE TO (c) Generalized arteriosclerosis												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19			20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 17, 1958 to July 22, 1958 that I last saw the deceased alive on July 22, 1958 , and that death occurred at 1:20p M , from the causes and on the date stated above.												
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-22-58												
ACTUAL SIGNATURE Stella Wachsler		M.D.										
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25/58		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Baltimore		22e. (State) 29 Ma				
23. FUNERAL DIRECTOR'S SIGNATURE 4131 Edmondson Ave.		ADDRESS				24a. REC'D BY REGISTRAR DATE JUL 25 '58		24b. REGISTRAR'S SIGNATURE Albert J. Schuch				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07765

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3501 Woodmoor Rd.		d. STREET ADDRESS 3501 Woodmoor Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALVAN	First W.	Middle WEBER	4. DATE OF DEATH July 10, 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1884
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber - self emp.		10b. KIND OF BUSINESS OR INDUSTRY Barber	
10c. BIRTHPLACE (State or foreign country) Md.		11. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Weber		14. MOTHER'S MAIDEN NAME Frances ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-30-2835	
17. INFORMANT Mrs. Ruth Ann Travis		Address 3501 Woodmoor Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Coronary occlusion myocardial infarct 18 hrs. DUE TO Rupture of myocardium hemopericardium 15 mins.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/28/58 , to 7/10/58 , that I last saw the deceased alive on 7/10/58 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Reiter</i>		ADDRESS (Street, city or town, state) 3408 Windsor Ave.	
PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.		DATE SIGNED 7/11/58	
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/58	
22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cem.		22d. LOCATION (City, town, or county) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Vickerer & Sons, Balt.</i>		24a. REC'D BY REGISTRAR DATE JUL 14 '58	
		24b. REGISTRAR'S SIGNATURE <i>Ans. rec'd</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a bind-and-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
EM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07768

7773

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Edgemere (19)

c. LENGTH OF STAY IN lb

40 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2510 S. Marine Ave.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Mary

Elizabeth

Welsh

4. DATE
OF
DEATH

July

13

1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

August 21, 1888

9. AGE in years
(less birthday)

69

yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (State or foreign country)

13. CITIZEN OF WHAT COUNTRY?

Housewife

Maryland

U.S.A.

14. FATHER'S NAME

Frederick Bush

14. MOTHER'S MAIDEN NAME

Margaret O. Shipley

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

NO

None

J.F. Welsh Sr.

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
15 Min.

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b) DUE TO

(c)

Arteriosclerotic Heart Disease

3 Yrs.

MEDICAL CERTIFICATION

Hypertension

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour _____
p.m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) _____ (State) _____

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Melvin B. Davis

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

8/4/58
(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

7/17/58

22c. NAME OF CEMETERY OR CREMATORIUM

Oak Lawn Cemetery

22d. LOCATION (City, town, or county)

Baltimore County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

W. Brooks Bradley Inc. Dundalk, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

AUG 7 '58

24b. REGISTRAR'S SIGNATURE

Aut. Davis

Replacement - Film 0232 8-7-58 at

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117767

7774 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO			2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Md b. COUNTY		
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] PARKVILLE			c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] PARKVILLE		
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION 2916 POTTY HILL Ave			d. STREET ADDRESS 2916 POTTY HILL Ave		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HERMAN		First H	Middle E	Last WERNER	4. DATE OF DEATH JULY
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1892	9. AGE (In years (last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER			10b. KIND OF BUSINESS OR INDUSTRY BTC		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Louis WERNER			14. MOTHER'S MAIDEN NAME Louisa SPANKE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO 218-10-3701		
17. INFORMANT Grace Mitchell			Address 2916 Potty Hill		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pharyngeal paralytic respiratory paralysis DUE TO CCIX			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Vascular accident; paralysis					
(c) Atherosclerosis Generalized Severe					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene right leg & foot due to arterial occlusion					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15, 1958 to July 29, 1958 , that I last saw the deceased alive on July 27, 1958 , and that death occurred at 5:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7527 Belair Rd Baltimore Md					
ACTUAL SIGNATURE John H. Kyle		M.D.		DATE SIGNED 7-29-58	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 31-1958		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore	
22d. LOCATION (City, town, or county) BALTO		(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son		ADDRESS 8808 Hartford Rd		24a. REC'D BY REGISTRAR DATE Aug. 3 1958	
24b. REGISTRAR'S SIGNATURE Red Smith					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed on page 3 should be detached for use on the burial-trust permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

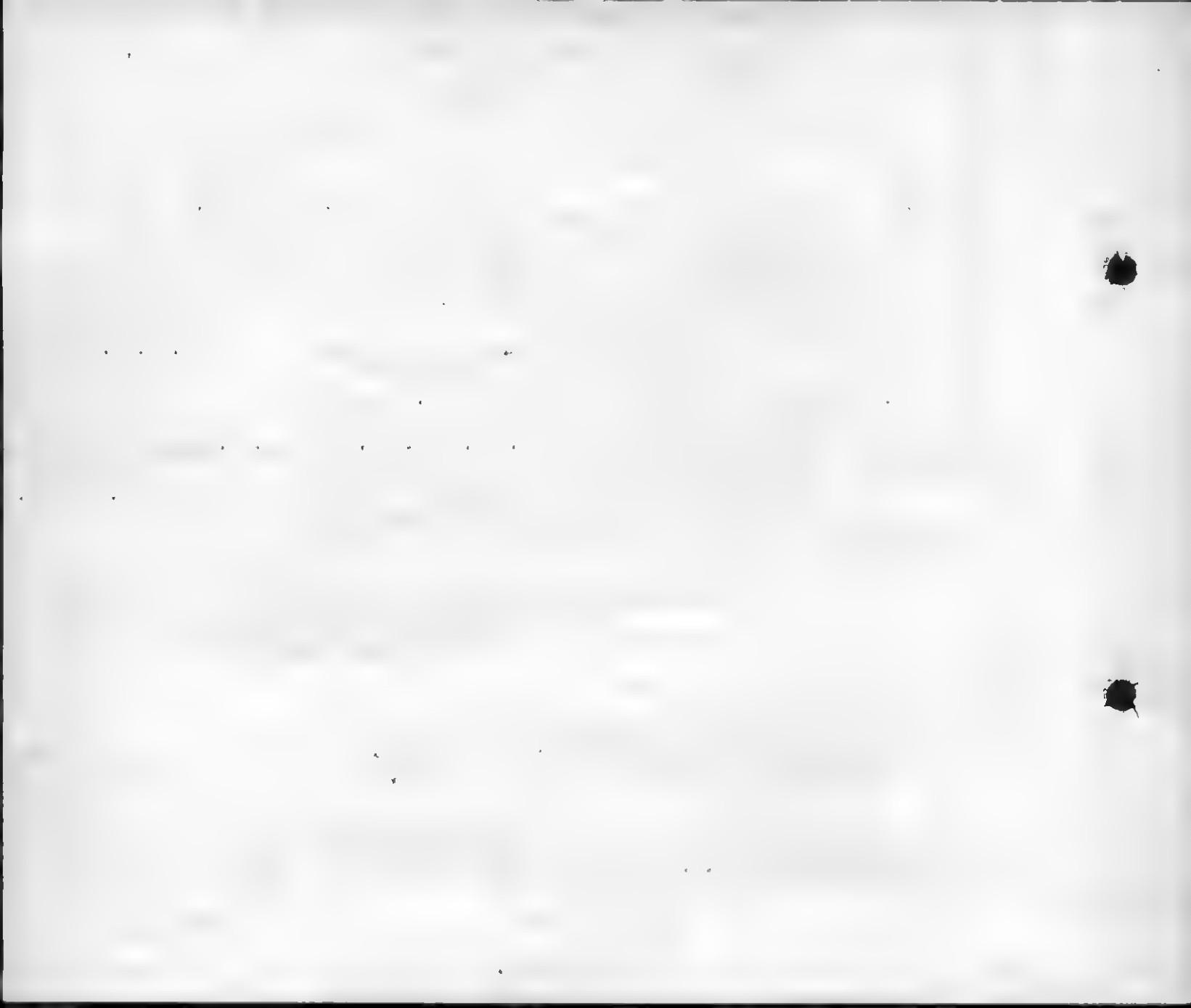
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7775 CERTIFICATE OF DEATH

Reg. Dist. No.

07768

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY P	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c LENGTH OF STAY IN lb 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d STREET ADDRESS 304 West Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First EDWARD	Middle J.	Last WHEELER	4. DATE OF DEATH July	Month July	Day 7	Year 1958
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 18, 1895	9 AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Record Clerk		10b. KIND OF BUSINESS OR INDUSTRY County Court (Balto.)		11. BIRTHPLACE (State or foreign country) Towson, Maryland		12 CITIZEN OF WHAT COUNTRY: U. S. A.	
13. FATHER'S NAME George F. Wheeler				14. MOTHER'S MAIDEN NAME Mary L. Stock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) Yes WW I		16. SOCIAL SECURITY NO. 215-12-3682		17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL ANEURYSM 4:1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO SEVERE GENERALIZED ARTERIOSCLEROSIS DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH SEVERAL HRS.							
UNKNOWN							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1958, to July 7, 1958, and that death occurred at 8:30 P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND							
DATE SIGNED 7/8/58							
ACTUAL SIGNATURE Chien Wei Lan							
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JULY 11, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS 612 York Road (Balto.) Towson, Md.		24a. REC'D BY REGISTRAR DATE JUL 11 '58		24b. REGISTRAR'S SIGNATURE A. L. Schaefer	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7776

CERTIFICATE OF DEATH

Reg. Dist. No.

07769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First IVON	Middle I	Last WILSON
4. DATE OF DEATH	Month July	Day 5	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/32
9. AGE (In years last birthday) 26 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Laundry	12. BIRTHPLACE (State or foreign country) Maryland
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes	14. MOTHER'S MAIDEN NAME Viola Cornish	15. SOCIAL SECURITY NO PL-28	16. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY THROMBOEMBOLI & PULMONARY INFARCTION 164X DUE BILATERAL Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) THROMBOPHEBLITIS LEFT LEG (c) PERITONITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cix			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 2, 1958, to July 5, 1958, and that death occurred at 10:10 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chien Wei Lan</i>	ADDRESS (Street, city or town, state) MD VAH Fort Howard, Maryland		
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.	DATE SIGNED 7/6/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/58	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE WILLINGTON S. PHILLIPS	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 8 '58	24b. REGISTRAR'S SIGNATURE <i>Albert L. Smith</i>



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the examiner. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7777 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland c. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 541 S. 45th Street		d. STREET ADDRESS 541 S. 45th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First K.	Middle VERNER	Last WIRTANEN
4. DATE OF DEATH	July	Month 17	Day 19
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1887
9. AGE (In years last birthday)	70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-str p mill	10b. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Finland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ? Wirtanen	14. MOTHER'S MAIDEN NAME Don't know		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. 442-1	17. INFORMANT Mrs. Elsie McCutcheon	Address Caruthers, Calif. 12251 S. Marks Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Occlusion DUE TO a-s-e-v- Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Autopsy	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Colgate, Md.
20f. (City or town) Colgate, Md.		(County) Colgate	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis	DATE SIGNED 7/19/58		
EXAMINER'S NAME (Type) M.B. Davis	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 21, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	22d. LOCATION (City, town, or county) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REG STRAR JUL 23 '58	24b. REG STRAR'S SIGNATURE Alfred E. Beck



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Dundalk</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk, Baltimore Md.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>6904 German Hill Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <i>John</i>	First	Middle	Last	4. DATE OF DEATH 7 11 1958	Month	Day	Year
--	-------	--------	------	-------------------------------	-------	-----	------

5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-14-1888</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Groceryman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
--	---	--	---

13. FATHER'S NAME <i>John Yurek</i>	14. MOTHER'S MAIDEN NAME <i>Mary Ann Novitzki</i>	Address <i>6904 German Hill Rd</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Anna R. Yurek</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>	420.1 DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	<i>(b)</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
---	------------------------	---	--	---------------------	----------	---------

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
--	--	--	--	--	--	--

ACTUAL SIGNATURE <i>JACK C Collins</i>	DATE SIGNED <i>7-11-58</i>
EXAMINER'S NAME (Type) <i>JACK C Collins</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-14-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart Of Mary</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Md.</i>
--	-------------------------------------	---	---	-----------------------

23. FUNERAL DIRECTOR'S SIGNATURE <i>Heller Dabrowski</i>	ADDRESS <i>1001A Dundalk Ave.</i>	24a. REC'D BY REGISTRAR DATE JUL 15 '58	24b. REGISTRAR'S SIGNATURE <i>Aleksandr</i>
---	--------------------------------------	--	--

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7778 CERTIFICATE OF DEATH

07772

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director, and page 3 should be detached for use of the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.		d. STREET ADDRESS 442 S. Chapelgate Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines Home				d. STREET ADDRESS 442 S. Chapelgate Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Lorelle	Middle M.	Last Zimmerman	4. DATE OF DEATH	Month July	Day 16	Year 1958
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1911	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Probation Officer		10b. KIND OF BUSINESS OR INDUSTRY City Courts		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Wm. Eugene Morris		14. MOTHER'S MAIDEN NAME Elizabeth A. Pfaff						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Helen Marshall 4904 Stafford St.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		Carcinoma of Breast with Metastasis		INTERVAL BETWEEN ONSET AND DEATH Unknown				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Jones J. Jones</i>		M.D.		ADDRESS (Street, city or town, state) 1700 Harbor 1100 Ave. Baltimore, Md.		DATE SIGNED		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-18-58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem		22d. LOCATION (City, town, or county) (State) Balto. Md		
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		ADDRESS Catonsville Md.		24a. REC'D BY REGISTRAR DATE JUL 18 '58		24b. REGISTRAR'S SIGNATURE <i>Albert Beach</i>		

BY COMMUNICATING TO THE STATE GOVERNOR

HTACO TO STANDING ROCK

RECEIVED

RECEIVED BY

RECEIVED BY	RECEIVED BY
-------------	-------------